

# **BALTIMORE CITY HEALTH DEPARTMENT RYAN WHITE CARE ACT, TITLE I QUALITY IMPROVEMENT PROGRAM (QIP)**

---

**SERVICE CATEGORY:**

**SUBSTANCE ABUSE TREATMENT SERVICES**

**JUNE 2003**



Prepared by:

**Training Resources Network**

Deborah Brimlow, PhD

Lori DeLorenzo, RN, MSN

Jeffrey A. Menzer, RN, ACRN

Susan Thorner, MA



## Table of Contents

<b>Introduction .....</b>	<b>2</b>
<b>Section 1. Methodology .....</b>	<b>2</b>
Table 1. Substance Abuse Treatment agencies reviewed, dates of review and number of Substance Abuse Treatment client records reviewed .....	3
Table 2. Number of Substance Abuse Treatment clients and proportion of Substance Abuse Treatment client records reviewed .....	4
<b>Section 2. Client Demographics .....</b>	<b>5</b>
Table 3. Gender distribution .....	5
Table 4. Age distribution .....	5
Table 5. Race/ethnicity distribution .....	5
Table 6. Race/ethnicity distribution by gender .....	6
Table 7. Risk factor distribution .....	6
Table 8. Risk factor distribution by gender .....	6
Table 9. Disease status, CD4 and viral load values, and treatment status .....	7
Table 10. Insurance status .....	8
Table 11. Residence .....	8
Table 12. Demographic comparison of client records reviewed with Baltimore City HIV/AIDS prevalence .....	9
Table 13. Proportion of client records reviewed by HRSA reporting category .....	9
<b>Section 3. Client-level assessment of compliance with EMA standards of care .....</b>	<b>10</b>
Table 14. Assessment of compliance with Standard of Care 1.0 .....	10
Table 15. Modalities of treatment specified in care plan .....	13
Table 16. Assessment of compliance with Standard of Care 1.2 .....	14
Table 17. Service status of clients at end of review period .....	17
Table 18. Reason for client termination from Substance Abuse Treatment services .....	17
<b>Section 4. Agency-level assessment of compliance with EMA standards of care .....</b>	<b>18</b>
Table 19. Services provided directly by Substance Abuse Treatment agencies or through referral agreements .....	18
Table 20. Agency-level assessment of compliance with Standard of Care 2.1 .....	19
Table 21. Agency-level assessment of compliance with Standard of Care 2.2 .....	20
Table 22. Agency-level assessment of compliance with Standard of Care 2.3 .....	21
Table 23. Agency-level assessment of compliance with Standard of Care 2.4 .....	22
<b>Section 5. Discussion .....</b>	<b>23</b>
<b>Section 6. Recommendations .....</b>	<b>25</b>
Table 24. Recommended Quality Indicators for Substance Abuse Treatment Services .....	26
<b>Appendices .....</b>	<b>27</b>

## Introduction

The Baltimore City Health Department (BCHD) Title I Quality Improvement Program (QIP) began in FY 2001, the purpose of which is to ensure that people living with HIV/AIDS (PLWH/A) in the Greater Baltimore Eligible Metropolitan Area (EMA) have access to quality care and services consistent with the Ryan White CARE Act. The FY 2001 QIP initiative focused on adult/adolescent primary care and case management services, while FY 2002 focused on medically related care and care coordination. The following service categories were reviewed during FY 2002:

- ✦ Substance abuse treatment services
- ✦ Mental health services: adults
- ✦ Mental health services: children and adolescents
- ✦ Case management adherence
- ✦ Client advocacy
- ✦ Co-morbidity services

To assess the degree to which the Operational and Performance Standards for Substance Abuse Treatment Providers (Standards of Care) as established by the Greater Baltimore HIV Health Services Planning Council (Planning Council) were adhered to across the EMA, baseline data was gathered and analyzed from all Title I vendors in the EMA funded to provide the services listed above. Information presented in this report focuses exclusively on Substance Abuse Treatment services.

## Section 1. Methodology

### Process

The one to three day QIP reviews were conducted at 100% of the nine agencies contracted to provide Substance Abuse Treatment services. Data was collected through three avenues: 1) consumer surveys; 2) agency surveys; and 3) client chart abstraction.

**Consumer Survey:** The Consumer Survey was designed to be completed by the clients. As needed, the Consumer Interviewer completed the tool while posing the questions to the client. The tool focused on three primary areas: a) general information about the consumer; b) services received; and c) level of involvement with the agency. The questions emphasized the type of services provided and client's knowledge about their care rather than on their satisfaction with services. Information related to consumer surveys is summarized in a separate report.

**Agency Survey:** Agency surveys were completed by 92% of the agencies providing Substance Abuse Treatment services. The tool is a self-report of how well the agency complies with the EMA's Standards of Care. No additional verification of information was undertaken. The contact person for the agency was responsible for completing the agency tool. Information related to the agency survey is presented in Section 4. (See Appendix C for a copy of the agency survey.)

**Client Chart Abstraction:** The chart abstraction tool was designed to assess the vendors' adherence to the EMA's Standards of Care. The tool, which was reviewed by BCHD and the Planning Council, was developed by a content expert with demonstrated expertise in the area of substance abuse treatment services. The tool contained items specifically relating to the Standards of Care, client demographics and descriptive items relating to service provision. (See Appendix B for a copy of the client chart abstraction tool.)

### Time Frame

The review period focused on services provided in FY 2001 (March 1, 2001 to February 28, 2002) for Title I clients. Based on the number of clients reported receiving Substance Abuse Treatment services during FY 2001, vendors were instructed to randomly select a specific number of patient records who received services in the defined time frame. Recommendations for obtaining a random sample were provided. In addition, vendors were instructed to include approximately ten records that represent services initiated in FY 2001 and three to five closed records. From the vendor-selected records, the QIP reviewers selected a specified, smaller number of records to review for adherence to the Standards. For each client record reviewed, one chart abstraction instrument was completed.

The individuals conducting the QIP reviews had expertise in the service category being reviewed. Reviewers were trained in the QIP process, received written instructions for completion of the client chart abstraction instrument, participated in an orientation conference call, and were provided additional guidance as needed during the QIP review process. All completed client chart instruments were reviewed for completeness and consistency and responses were entered into a customized database for subsequent analysis.

### Sample

A total of 1,158 clients were reported to have received services during FY 2001. A total of 306 Substance Abuse Treatment services client records were reviewed at the nine directly funded agencies, representing a total of 18.7% of all reported Title I clients. The number of records reviewed per site ranged from 10 to 42, with an average of 24 records reviewed per site (Table 1). The proportion of agency's clients records reviewed ranged from 9% to 95.6% of all reported Title I clients (Table 2).

**Table 1. Substance Abuse Treatment agencies reviewed, dates of review and number of Substance Abuse Treatment client records reviewed**

Agency Name	Dates of review	Number of records reviewed during QIP	% of QIP total
Baltimore Substance Abuse System (BSAS)	November 12 — 14, 2002	35	16.1%
Bon Secours Health Systems	October 16 — 17, 2002	19	8.8%
Chase Brexton Health Services	October 7 — 9, 2002	23	10.6%
Health Care for the Homeless	November 20 — 21, 2002	26	12%
Johns Hopkins University/Dept of Psychiatry	November 6 — 8, 2002	42	19.4%
Johns Hopkins University/Women's Program	November 15, 2002	22	10.1%
People's Community Health Center	October 3, 2002	10	4.6%
South Baltimore Family Health Center	November 19, 2002	20	9.2%
University of Maryland	December 4 — 6, 2002	20	9.2%
<b>Total</b>		<b>217</b>	<b>100%<sup>1</sup></b>
Average		24	9%
<b>Minimum</b>		<b>10</b>	<b>4.6%</b>
Maximum		42	19.4%

<sup>1</sup> Note on all tables: Due to rounding, the total may not be equal to one hundred percent.

**Table 2. Number of Substance Abuse Treatment clients and proportion of Substance Abuse Treatment client records reviewed**

Agency Name	Reported # of Title I clients receiving Substance Abuse treatment services	% of EMA total	% of agency's clients reviewed by QIP
Baltimore Substance Abuse System (BSAS)	386	33.3%	9%
Bon Secours Health Systems	24	2%	79.1%
Chase Brexton Health Services	248	21.4%	9.2%
Health Care for the Homeless	49	4.2%	53%
Johns Hopkins University/Dept of Psychiatry	188	16.2%	22.3%
Johns Hopkins University/Women's Program	23	1.9%	95.6%
People's Community Health Center	44	3.7%	22.7%
South Baltimore Family Health Center	57	4.9%	35%
University of Maryland	139	12.0%	14.3%
<b>Total</b>	<b>1,158</b>	<b>100%</b>	<b>18.7%</b>
Average	128	11%	37.80%
<b>Minimum</b>	<b>23</b>	<b>2%</b>	<b>9%</b>
Maximum	386	33.3%	95.6%

## Section 2. Client Demographics

### Gender and Age

Of the population sampled, the majority of clients (55.8%) were male and 43.8% female (Table 3). The mean age of clients was 42.7 years, with men being older than women (Table 4).

**Table 3. Gender distribution**

Gender	n=217
Female	95 (43.8%)
Male	121 (55.8%)
Missing/Not abstracted	1 (<1%)

**Table 4. Age distribution**

Age	n=217
13 – 19 years	1 (<1%)
20 – 29 years	6 (2.8%)
30 – 39 years	74 (34.1%)
40 – 49 years	93 (42.9%)
50 – 59 years	38 (17.5%)
60 – 69 years	2 (1%)
>70 years	1 (<1%)
Not documented	2 (1%)
Mean age (n=214)	42.7 years
Min 19.7 years	
Max 76.0 years	
Mean age Male (n=119)	43.9 years
Min 26.6 years	
Max 59.7 years	
Mean age Female (n=95)	41.1 years
Min 19.7 years	
Max 76.0 years	

### Race/Ethnicity

Eighty-two percent (82.5%) of the clients were African-American, and 13.4% were White (Table 5). Of the women, 81.1% were African-American and 13.7% were White (Table 6).

**Table 5. Race/ethnicity distribution**

Race/Ethnicity	n=217
African-American	179 (82.5%)
White	29 (13.4%)
Hispanic	1 (<1%)
American Indian/Alaska Native	1 (<1%)
Other	2 (1%)
Not documented	1 (<1%)
Missing/Not abstracted	4 (1.8%)

Table 6. Race/ethnicity distribution by gender

Race/Ethnicity	Male	Female	Not doc. /Missing	Total
African-American	102 (84.3%)	77 (81.1%)	—	179 (82.5%)
White	16 (13.2%)	13 (13.7%)	—	29 (13.4%)
Hispanic	1 (<1%)	—	—	1 (<1%)
American Indian/Alaska Native	—	1 (<1%)	—	1 (<1%)
Other	—	2 (2.1%)	—	2 (<1%)
Not documented/Missing	2 (1.6%)	2 (2.1%)	1 (100%)	5 (2%)
<b>Total</b> <b>(% of column)</b>	<b>121</b> <b>(100%)</b>	<b>95</b> <b>(100%)</b>	<b>1</b> <b>(100%)</b>	<b>217</b> <b>(100%)</b>

Note: In this table, Not Documented and Missing/Not abstracted categories have been combined.

### Risk Factor

Slightly more than two-fifths (41.5%) had an injection drug use-related (IDU) risk factor, followed by IDU and heterosexual contact (21.2%) and heterosexual contact (11.5%). Risk factor was not documented for 12.4% of all clients (Table 7).

Almost one-half of the men (47.1%) had IDU-related risk factors. Slightly more than one-third (34.7%) of women had an IDU-related risk factor. Eighteen percent (18.1%) of the men had either a MSM or MSM and IDU risk factor (Table 8).

Table 7. Risk factor distribution

Risk Factor	n=217
IDU	90 (41.5%)
IDU and Heterosexual	46 (21.2%)
Heterosexual	25 (11.5%)
MSM	15 (6.9%)
MSM and IDU	7 (3.2%)
Hemophilia/coagulation	1 (<1%)
Other	1 (<1%)
Undetermined/Unknown	2 (<1%)
Not documented	27 (12.4%)
Missing/Not abstracted	3 (1.4%)

Table 8. Risk factor distribution by gender

Risk Factor	Male	Female	Not doc. /Missing	Total
IDU	57 (47.1%)	33 (34.7%)	—	90 (41.5%)
IDU and Heterosexual	13 (10.7%)	33 (34.7%)	—	46 (21.2%)
Heterosexual	9 (7.4%)	15 (15.8%)	1 (100%)	25 (11.5%)
MSM	15 (12.3%)	—	—	15 (6.9%)
MSM and IDU	7 (5.8%)	—	—	7 (3.2%)
Hemophilia/coagulation	1 (<1%)	—	—	1 (<1%)
Other	—	1 (1%)	—	1 (<1%)
Undetermined/Unknown	—	2 (2.1%)	—	2 (<1%)
Not documented/Missing	19 (15.7%)	11 (11.5%)	—	30 (13.8%)
<b>Total</b> <b>(% of column)</b>	<b>121</b> <b>(100%)</b>	<b>95</b> <b>(100%)</b>	<b>1</b> <b>(100%)</b>	<b>217</b> <b>(100%)</b>

Note: In this table, Not Documented and Missing/Not abstracted categories have been combined.

### Disease status and biological indicators

Of the population sampled, 16.6% of clients had an AIDS diagnosis (Table 9). Disease status was not documented for slightly more than 3% of the clients. Slightly more than half (54.8%) of clients had a CD4 value documented in their record. The mean CD4 value was 335.0/ mm<sup>3</sup>, with women having a higher mean CD4 than men, 401.1/ mm<sup>3</sup> and 293.2 mm<sup>3</sup>, respectively. Seven percent (7.1%) had a CD4 value which indicates severe immunological compromise (<50/ mm<sup>3</sup>), while almost one-quarter (23.5%) had CD4 values greater than 500/mm<sup>3</sup>.

Only 36.4% of clients had a viral load documented in their record. About eighteen percent (17.7%) had an undetectable viral load while almost one-half (45.6%) had a viral load of greater than 20,000 c/mL. Almost one quarter (23%) of clients were documented being on HAART during the review period, although treatment status was documented for only almost one-half (47%) of clients.

**Table 9. Disease status, CD4 and viral load values, and treatment status**

<b>Disease Status</b>		<b>n=217</b>
CDC-Defined AIDS		36 (16.6%)
HIV-infection		168 (77.4%)
Deceased		3 (1.4%)
Not documented		7 (3.2%)
Missing/Not abstracted		3 (1.4%)
<b>CD4 Distribution</b>		<b>n=119</b>
<50/mm <sup>3</sup>		7 (7.1%)
50 – 199/mm <sup>3</sup>		28 (28.6%)
200 – 499/mm <sup>3</sup>		40 (40.8%)
> 500/mm <sup>3</sup>		23 (23.5%)
CD4 values were not documented for 98 (45%) of all reviewed client records.		
<b>Mean CD4 Values</b>		
Mean CD4 (n=98)		335.0/ mm <sup>3</sup>
Mean CD4 Male (n=60)		293.2/ mm <sup>3</sup>
Mean CD4 Female (n=38)		401.1/ mm <sup>3</sup>
<b>Viral Load Distribution</b>		<b>n=79</b>
Undetectable		14 (17.7%)
1 – 999 c/mL		10 (12.7%)
1000 – 6,999 c/mL		5 (6.3%)
7,000 -19,999 c/mL		14 (17.7%)
20,000 – 54,999 c/mL		12 (15.2%)
> 55,000 c/mL		24 (30.4%)
Viral load values were not documented for 138 (64%) of all reviewed client records.		
<b>Treatment Status</b>		<b>n=217</b>
% documented on HAART at any time during review period		23%
Treatment status was not documented for 116 (53%) of all reviewed client records.		

### Insurance status

Insurance coverage was documented at the beginning or first entry of the review period and at the end or last entry of the review period. At the first entry, 28.1% of clients had Medicaid insurance (Table 10). One-quarter (25.3%) had no insurance coverage. Of those who did not have any form of insurance at the first entry, 12.7% had some form of insurance coverage at the second entry—most obtaining Medicaid during the review period.

**Table 10. Insurance status**

Insurance status	First Entry
Medicaid	61
MPAP	5
No insurance	55
MADAP	2
Medicare	5
Private/Commercial	0
MPC	1
Veteran's Administration	1
Not documented	82
Missing/Not abstracted	3

Note: Multiple responses documented.

### Residence

The most frequent ZIP code of client residence was 21218, followed by 21213, 21217, and 21223. ZIP code was not documented for 6% of records, but city of residence (Baltimore) was noted. Information about residence was not documented in 2% of the records reviewed (Table 11).

**Table 11. Residence**

ZIP code	# (% of total)
21218	27 (12%)
21213	15 (7%)
21217	15 (7%)
21223	15 (7%)
Baltimore/ZIP code not documented	14 (6%)
21225	13 (6%)
21216	12 (5%)
21202	11 (5%)
21205	10 (5%)
21201	9 (4%)
21224	9 (4%)
21229	9 (4%)
21230	9 (4%)
21215	8 (4%)
21206	3 (1%)
21221	3 (1%)
21231	3 (1%)
21207	2 (<1%)
21208	2 (<1%)
21211	2 (<1%)
21212	2 (<1%)
21214	2 (<1%)
21220	2 (<1%)
21244	2 (<1%)
21403	2 (<1%)
20708	1 (<1%)
20785	1 (<1%)
21061	1 (<1%)
21203	1 (<1%)
21210	1 (<1%)
21222	1 (<1%)

ZIP code	# (% of total)
21227	1 (<1%)
21239	1 (<1%)
21270	1 (<1%)
21405	1 (<1%)
21715	1 (<1%)
Residence not documented in record	5 (2%)
<b>Total</b>	<b>217 (100%)</b>

### Comparison with Baltimore City EMA prevalence data<sup>2</sup>

In comparison with reported Baltimore City EMA HIV/AIDS prevalence, the sample of records reviewed has a slightly higher proportion of Whites and lower proportion of African-Americans. The sample of records has a larger representation of women and higher proportion of adults in the 30-39 year age range.

**Table 12. Demographic comparison of client records reviewed with Baltimore City HIV/AIDS prevalence**

Population	Reviewed client records	Baltimore City HIV/AIDS prevalence
African-American	82.5%	89.0%
White	13.4%	9.9%
Adult Male (>13 years)	55.8%	62.7%
Adult Female (>13 years)	43.8%	37.3%
Ages 30 – 39 years	34.1%	30.0%
Ages 40 – 49 years	42.9%	42.0%
Ages 50 – 59 years	17.5%	15.6%

### HRSA reporting categories

Client demographics by HRSA reporting categories are reported below.

**Table 13. Proportion of client records reviewed by HRSA reporting category**

Population	Reviewed client records
0 – 12 months	0%
1 – 12 years	0%
13 – 24 years	<1%
Women >= 25 years	43.3%
African-American/Female	35.4%
African-American/Male	46%

<sup>2</sup> Baltimore City Health Department, HIV Surveillance Program, “Baltimore City HIV/AIDS Epidemiological Profile,” Third Quarter 2002. Prevalence data on September 30, 2001 as reported through September 30, 2002.

### Section 3. Client-level assessment of compliance with EMA standards of care

#### A. Initial Evaluation (Standard of Care 1.1)

Standard of Care 1.1 focuses on the key components of initial evaluations for clients referred for substance abuse treatment services. As part of the initial evaluation, a client history, mental status exam, cognitive assessment, and laboratory findings are to be assessed. In addition, a multi-axial diagnosis and treatment plan are to be identified and established. Based on the findings, care is to be rendered in a manner consistent with practice guidelines. A total of 105 clients entered treatment for substance abuse services during the review period, representing 48% of the total sample of client records (n=217). Table 14 outlines compliance with the various components of the initial evaluation.

**Table 14. Assessment of compliance with Standard of Care 1.0**

EMA Standard	Percent of reviewed client records meeting Standards	
Initial evaluation must be conducted prior to the initiation of treatment. [SA Standard 1.1]	81%	(n=105)
Initial evaluation must be conducted by clinical staff who are knowledgeable about the full spectrum of alcohol and drug addiction. Clinical staff should be working in a substance abuse program certified/license (sic) which is recognized by either the State of Maryland Office of Health Care Quality accreditation on rehabilitation facilities; or hold a current certification/license which is recognized by the Maryland Alcohol and Drug Abuse Administration for practice in the State of Maryland. [SA Standard 1.1]	82%	(n=105)
Initial evaluation documents client history. [SA Standard 1.1.a]	87%	(n=105)

Client history item	% included (n=91)
Past substance abuse history	98%
Current substance abuse history	95%
Chief complaint	91%
Family history	78%
Past psychiatric history	74%
Medical history	69%
Social and personal history	56%
Current and recent medications	46%
Review of systems	34%
Premorbid personality	13%
<b>Mean percent completeness of client history</b>	<b>65%</b>

Only those charts with a documented client history (91 of 105) were included in the table above.

---

Initial evaluation documents mental status evaluation. 47% (n=105)  
[SA Standard 1.1.b]

Mental status evaluation item	% included (n=49)
Appearance	94%
Behavior	90%
Mood	84%
Talk	73%
Suicidal risk	67%
Homicidal risk	35%
Self attitude	27%
Perceptual disturbances	24%
Vital sense	18%
Abnormal beliefs	16%
Obsessions/compulsions, phobias, and panic attacks	14%
<b>Mean percent completeness of mental status evaluation</b>	<b>45%</b>

Only those charts with documented mental status evaluation (49 of 105) were included in the table above.

---

Initial evaluation documents cognitive assessment. 47% (n=105)  
[SA Standard 1.1.c]

Cognitive assessment item	% included (n=49)
Level of consciousness	98%
Orientation	98%
Memory	63%
Language	22%
Mini-Mental Status and Verbal Trails Test	22%
<b>Mean percent completeness of cognitive assessment</b>	<b>49%</b>

Only those charts with documented cognitive assessment (49 of 105) were included in the table above.

---

Initial evaluation documents completion of Addiction Severity Index (ASI) or the Problem Oriented Screening Instrument for Teenagers (POSIT). 24% (n=105)  
[SA Standard 1.1.d]

---

Initial evaluation documents laboratory studies, as indicated. 40% (n=105)  
[SA Standard 1.1.e]

---

Initial evaluation documents multi-axial differential diagnosis leading to final diagnostic formulation. 49% (n=105)  
[SA Standard 1.1.f]

---

Development of treatment plan [with specific measurable treatment goals through the appropriate use of outcome assessment.] (n=105)  
[SA Standard 1.1.g]

76% have treatment plan

80% of these treatment plans have goals (n=80)

61% of these treatment plans contain method of outcome assessment (n=80)

*Includes only those with a treatment plan; 25 excluded from analysis.*

---

Documentation of treatment plan that addresses full range of substances a patient/client is abusing. [SA Standard 1.1.g]	68%	(n=80)	<i>Includes only those with a treatment plan; 25 excluded from analysis.</i>
Documentation of input from patient/client in treatment plan. [SA Standard 1.1.g]	78%	(n=80)	<i>Includes only those with a treatment plan; 25 excluded from analysis.</i>
Practice guidelines for substance abuse use disorders, such as those published by the American Society of Addition Medicine [should inform the treatment plans.] <sup>3</sup> [SA Standard 1.1.h]	76%	(n=80)	<i>Includes only those with a treatment plan; 25 excluded from analysis.</i>

Of the 105 clients who initiated substance abuse services during the review period, 81% had an initial evaluation completed (Standard 1.1). According to Standard 1.1, the initial evaluation must be conducted by “clinical staff who are knowledgeable about the full spectrum of alcohol and drug addiction. Clinical staff should be working in a substance abuse program certified/license (sic) by either the State of Maryland Office of Health Care Quality Accreditation on Rehabilitation Facilities; or hold a current certification/license which is recognized by the Maryland Alcohol and Drug Abuse Administration for practice in the state of Maryland”. Of the records reviewed, 82% met this Standard.

Standard 1.1.a states that an initial evaluation must document a client history and specifies 10 items to assess. Ninety-one of the 105 records (87%) contained a client history and consistently documented past substance use history (98%), current substance abuse history (95%), the chief complaint (91%), family history (78%), and past psychiatric history (74%). Items with a low rate of completion included the following: premorbid personality (13%) and review of systems (34%). On average, approximately 6 of the 10 assessment items were documented as part of the completed client histories.

As part of the initial evaluation, a complete mental status evaluation should also be completed (Standard 1.1.b). Of the 105 records reviewed, 47% contained a mental status evaluation and consistently documented appearance (94%), behavior (90%), and mood (84%). The following items had lower rates of completion: obsessions/compulsions, phobias, and panic attacks (14%), abnormal beliefs (16%), vital sense (18%), perceptual disturbances (24%), and self attitude (27%). A cognitive assessment was documented in 47% of the 105 records reviewed (Standard 1.1.c). As part of the cognitive assessment, the highest rates of completion were for level of consciousness (98%), orientation (98%), and memory (63%). The lowest rates of completion were noted for the Mini-Mental Status and Verbal Trails Test (22%) and language (22%).

The completion of the Addiction Severity Index (ASI) was documented in only 24% of the 105 records reviewed (Standard 1.1.d). While the standard also mentions the Problem Oriented Screening Instrument for Teenagers (POSIT) as a severity index, none of the records reviewed documented completion of this tool.

<sup>3</sup> The published Standard 1.1.h appears incomplete. The edited addition to the Standard is from the Operational and Performance Standards for Mental Health Providers, Section 4. page 1, Standard 1.1.g.

Laboratory studies, as indicated, were documented in the initial evaluation in 40% of the 105 records reviewed (Standard 1.1.e).

Standard 1.1.f states that an initial evaluation must document a multi-axial differential diagnosis leading to a final diagnostic formulation. Of the 105 records reviewed, 49% documented a multi-axial differential diagnosis. The most frequent diagnoses for Axis I were opioid dependence, cocaine dependence, and alcohol dependence. There were very few Axis II diagnoses documented (n=7). Of those, the most common were antisocial personality disorder (n=2) and borderline personality disorder (n=2). Axis III diagnoses were primarily HIV/AIDS. For Axis IV, the main diagnoses documented were problems with the primary support group, occupational problems, and economic problems. Seventy one percent (71%) of clients with a multi-axial differential diagnosis had a documented current Global Assessment of Functioning (GAF) on Axis V with scores ranging from 5 to 75 and 22% contained documentation of the highest GAF in the previous 12 months documented with scores ranging from 40 to 65. (See Appendix A for a further description of client diagnoses.)

While treatment plans, with specific measurable goals, are to be established for all clients (Standard 1.1.g), 76% of the 105 records reviewed contained such treatment plans. Specific, measurable treatment goals were documented in 80% of the treatment plans and outcome assessment methods were documented in 61% of the treatment plans. **Issues relating to the client's HIV-related care and/or status were addressed in less than a quarter (24%)** of the treatment plans. Other issues of concern to the patient, such as housing, employment and medical care, were addressed in 24% of the treatment plans. Standard 1.1.g states that the treatment plan must include input from the patient/client. This was documented in 78% of the treatment plans reviewed.

In 65% of the treatment plans, group counseling was the primary treatment modality specified followed closely by individual counseling (64%). Some treatment plans contained multiple modalities including detoxification, self-help group, methadone, psychiatric treatment, and residential treatment (Table 15).

**Table 15. Modalities of treatment specified in treatment plan**

Modality specified in treatment plans	# (% of treatment plans) n=80
Group counseling	52 (65%)
Individual counseling	51 (64%)
Detoxification	26 (33%)
Self-help group	17 (21%)
Methadone	13 (16%)
Psychiatric treatment	10 (13%)
Residential treatment	3 (4%)
Other: Intensive patient therapy	3 (4%)
Individual/Psychodynamic	1 (1%)
Emergency treatment	1 (1%)

Note: Multiple responses documented.

In 76% of the 80 treatment plans reviewed, the plan was consistent with practice guidelines for the indicated substance use disorders (Standard 1.1.h). However, for 14 cases, the treatment plan was not consistent with treatment guidelines for the indicated diagnosis. For the majority of cases, the treatment plan was not adequately individualized to the client's assessed needs and diagnosis.

## B. Follow-Up Visits (Standard of Care 1.2)

As with the “Initial Evaluation” Standards (1.1), Standard of Care 1.2 outlines a series of key activities related to the provision and monitoring of care and treatment over time. All records reviewed (n=217) were assessed for compliance with the Standards relating to follow-up care and treatment. Table 16 outlines compliance with the various components of Standard 1.2.

**Table 16. Assessment of compliance with Standard of Care 1.2**

EMA Standard	Percent of reviewed client records meeting Standards	
Documentation of treatment plan. [SA Standard 1.1f]	68%	(n=217)
Documentation of patient visits. [SA Standard 1.2.a]	95%	(n=217)
Documentation of frequency of visits based on level of care and severity of need. [SA Standard 1.2.a]	81%	(n=217)
Documentation of provision of supportive and educational counseling at all visits. [SA Standard 1.2.b]	64%	(n=217)
Documentation of provision of supportive and educational counseling regarding prevention of “HIV transmitting behaviors”. [SA Standard 1.2.b]	30%	(n=217)
Documentation of provision of supportive and educational counseling regarding “substance abuse”. [SA Standard 1.2.b]	65%	(n=217)
Documentation of provision of medications under the supervision of a physician or psychiatrist. [SA Standard 1.2.c]	99%	(n=127)
	<i>Includes only those 127 clients receiving medication; 90 excluded from analysis.</i>	
Documentation of monitoring of medications. [SA Standard 1.2.c]	74%	(n=127)
	<i>Includes only those 127 clients receiving medication; 90 excluded from analysis.</i>	
Documentation of medication side effect monitoring. [SA Standard 1.2.d]	55%	(n=127)
	<i>Includes only those 127 clients receiving medication; 90 excluded from analysis.</i>	
Documentation of teaching patient about medications. [SA Standard 1.2.d]	28%	(n=127)
	<i>Includes only those 127 clients receiving medication; 90 excluded from analysis.</i>	
Documentation of provision of group psychotherapy or counseling as indicated by the clinical situation based on practice guideline recommendations and linked to specific treatment goals. [SA Standard 1.2.e]	63%	(n=217)

---

Documentation of monitoring of treatment plan goal attainment through the use of appropriate treatment outcome assessment. 78% (n=217)  
[SA Standard 1.2.f]

Method of assessment (n=217)	# (% of charts)
Toxicology screening	99 (46%)
Patient self report	78 (40%)
Documentation of substance abuse treatment status	73 (34%)
Documentation of patient social indicators	46 (21%)
Documentation of multi-disciplinary meetings/collaboration with other providers	43 (19%)

Note: Multiple values documented.

---

Documentation of inclusion of patient in monitoring of treatment plan goal attainment. 43% (n=217)  
[SA Standard 1.2.f]

---

Documentation of treatment plan reassessment at least every three months. 41% (n=98)  
[SA Standard 1.2.g]

*Includes only 98 records eligible for a three month reassessment. 68% of the reviewed charts contained a treatment plan (n=147). Of these, 49 were excluded from analysis because they received services for less than three months and were not expected to have a review.*

---

Formal treatment plans were documented in 68% of the 217 records reviewed (Standard 1.1.f). Documentation of patient visits was contained in 95% of the records reviewed. Standard 1.2.a indicates the visit frequency should be based on level of care and severity of need. Of the records reviewed, 81% documented appropriate visit frequency (Standard 1.2.a).

Supportive and educational counseling at all visits is documented in 64% of the records reviewed (Standard 1.2.b). The Standard further specifies that this education and counseling should include, if clinically indicated, counseling regarding prevention of HIV-transmitting behaviors and substance abuse. Only 30% of records documented any HIV prevention counseling. Substance abuse counseling was documented in 65% of the records reviewed.

Standards 1.2.c and 1.2.d focus on the prescription and monitoring of appropriate psychotropic or other medications, such as LAAM (L-alpha-acetylmethadol) and methadone, as indicated by the clinical situation, evidence-based practice guideline recommendations, and linkage to specific treatment guidelines. Standard 1.2.c states that medications must be provided under the supervision of a physician/psychiatrist.

Of the 217 records reviewed, 58% indicated that medications associated with their substance abuse treatment were prescribed by the substance abuse treatment services provider, and 99% of the time were prescribed by a physician/psychiatrist. For the clients prescribed medication, there was documentation of routine and appropriate monitoring of medications under the supervision of a physician/psychiatrist contained in 74% of the records reviewed. The methods used to monitor the medications include laboratory monitoring, patient interviews, other physician observation, and patient surveys.

Standard 1.2.d addresses side effect management and medication teaching for clients. Of the records reviewed, 55% of the records documented routine and appropriate side effect management for clients receiving medications. The methods used to assess side effects included patient interviews, laboratory monitoring, other physician observation, and physical assessment of the patient.

Fewer records contained documentation related to medication teaching. Less than a third (28%) of the records contained documentation that patients had received teaching about their medications. Two-thirds of patients had received one-to-one teaching by a member of the health care team. Slightly less than two-thirds (61%) received written materials. Approximately 30% were referred to an educator or to group education sessions. Content documented in the record included the expected benefit of medications, the importance of medication adherence, and common and potentially serious side effects of medications.

Standard 1.2.e addresses the provision of group psychotherapy or counseling as indicated by the clinical situation based on practice guideline recommendations and linked to specific treatment goals. Of the 217 records reviewed, 63% met the standard.

Standard 1.2.f focuses on monitoring the patient's progress towards treatment goals through the use of appropriate outcome assessments, which must include input from the client. Of the 217 records reviewed, more than three-quarters (78%) documented the use of outcome assessments to monitor progress toward treatment goals. Methods of assessment of treatment outcomes included toxicology screening (46%), patient self report (40%), documentation of substance abuse treatment status (34%), documentation of patient social indicators (21%), and documentation of multi-disciplinary meetings/collaboration with other providers (19%).

Patient inclusion in monitoring/assessment of progress towards treatment goals was documented in 43% of the 217 records reviewed (Standard 1.2.f).

Standard 1.2.g outlines a three month time interval for reassessment of the treatment plan and assessment of progress made towards goal attainment. Of the 98 records that contained a treatment plan and were eligible for reassessment every three months, 41% of the records documented reassessment.

### **C. Termination and Discharge Planning**

There are no specific Standards regarding termination and discharge planning. Of the 217 records reviewed, 42% of clients continued to receive services through the end of the review period. Forty-three percent (43%) of clients did not continue in care. Fourteen percent (14%) of clients completed care and 29% of clients were terminated by the provider (Table 17). Reasons for termination included client leaving against medical advice (AMA), non-compliance with treatment, missed appointments, client death, client incarceration, transfer of care to another agency, and client hospitalization (Table 18). Client status was not documented in 11% of the records reviewed.

**Table 17. Service status of clients at end of review period**

<b>Client status at end of review period</b>	<b>#/% of total</b>
Client continued in treatment	91 (42%)
Client terminated treatment	64 (29%)
Client completed treatment	31 (14%)
Client status not documented	23 (11%)
Missing/not abstracted	8 (4%)
<b>Total</b>	<b>217 (100%)</b>

**Table 18. Reason for client termination from Substance Abuse Treatment services**

<b>Reason for termination</b>	<b>#/% of total</b>
Client termination/AMA	19 (30%)
Client non-compliance	16 (25%)
Client missed appointments	13 (20%)
Reason not documented/Missing	5 (8%)
Client death	3 (5%)
Client incarceration	3 (5%)
Client transferred treatment to another provider	3 (5%)
Client hospitalization	2 (3%)
<b>Total</b>	<b>64 (100%)</b>

Additional data were collected regarding discharge planning and continuity of care. Thirty-nine percent (39%) of the records reviewed documented appropriate discharge planning for clients and slightly more than a quarter (27%) documented the inclusion of the client in the discharge planning. Fewer than 20% of the records documented referrals to primary care, case management and/or ancillary care.

## Section 4. Agency-level assessment of compliance with EMA standards of care

As part of the QIP process, agencies providing substance abuse treatment services were asked to complete a six page survey (See Appendix C for a copy of the instrument). The purpose of this survey was to document the self-reported compliance with the EMA's Operational and Performance Standards for Substance Abuse Treatment Providers pertaining to agency policies and procedures. All data presented is self-reported by the surveyed agencies and the QIP process did not verify the agencies' responses.

Nine agencies in the Baltimore EMA receive Title I funds for substance abuse services. Of these agencies, 8 completed the survey. Three additional surveys were completed by agencies that serve as subcontractors to one of the funded agencies (n=11).

Table 19 lists the services directly provided by the agencies delivering substance abuse treatment services and those provided through referral agreements. The 11 agencies discussed here provide a large number of other services to clients and range from ambulatory health care to ancillary and supportive services, such as transportation and direct emergency assistance. The agencies also report having access to a wide array of services through referral agreements. This is especially evident in the high percentage (73%) of agencies who provide substance abuse treatment services by referral in addition to the services provided directly. Agencies are more likely to provide the following services by referral: inpatient detoxification, outpatient detoxification, long-term structured program, LAMM, methadone, and 12-step programs.

**Table 19. Services provided directly by Substance Abuse Treatment agencies or through referral agreements.**

Service category (n=11)	% which provide service directly	% with referral agreements
Substance Abuse Treatment	100%	73%
SA-Individual Counseling	82%	18%
SA-Group Counseling	46%	9%
SA-12-Step Programs	27%	27%
SA-Outpatient Detoxification	27%	36%
SA-Methadone	18%	73%
SA-Inpatient Detoxification	9%	36%
SA-LAMM	9%	27%
SA-Long-term Structured Program	9%	36%
Ambulatory Health Care	55%	27%
Case Management	55%	9%
Case Management Adherence	55%	0%
Co-morbidity Services	55%	0%
Counseling	55%	18%
Mental Health Services	55%	27%
Outreach	46%	18%
Transportation	46%	18%
Viral Load Testing	46%	27%
Client Advocacy	36%	9%
Dental Care	27%	18%
Direct Emergency Assistance	27%	27%
Housing Assistance	27%	36%
Food/Nutrition	18%	64%
Legal Services	9%	9%

Service category	% which provide service directly	% with referral agreements
Other: Administrative	9%	—
Other: HIV/CTS	9%	—
Other: OB/GYN	9%	—
Buddy/Companion	0%	0%
Enriched Life Skills	0%	9%
Other: Needle exchange program	—	9%

### A. Licensing, Knowledge, Skills and Experience (Standard of Care 2.1)

The agencies surveyed report relatively high rates of compliance with standards relating to staff licensing, knowledge, skills, and experience (Standard 2.1) (Table 20).

Of the 11 agencies, 82% report that the agencies and staff are all appropriately licensed (Standard 2.1.a). Professional supervision of non-licensed staff or trainees is reported by 73% of the agencies (Standard 2.1.b). Ninety-one percent (91%) of the agencies report that staff members either have specific experience in caring for HIV-positive clients or receive appropriate training (Standard 2.1.c).

**Table 20. Agency-level assessment of compliance with Standard of Care 2.1**

EMA Standard	Percent of agencies reporting compliance with Standard	
All agencies and staff delivering substance abuse treatment services will possess current certification and/or licensure. (Standard 2.1.a)	82%	(n=11)
Non-licensed staff or trainees delivering substance abuse treatment services will receive professional supervision of the care they are providing to individual patients/clients, by a licensed or certified providers. (Standard 2.1.b)	73%	(n=11)
All staff delivering substance abuse treatment services will either have specific experience in caring for HIV infected patients or receive appropriate training. (Standard 2.1.c)	91%	(n=11)

### B. Patient Rights and Confidentiality (Standard of Care 2.2)

Standards 2.2.a and 2.2.b both address policies and procedures relating to patient rights (Table 21).

Of the 11 agencies surveyed, 82% report compliance with policies and procedures relating to confidentiality (Standard 2.2.b). Seventy-three percent (73%) of the agencies indicate they have policies and procedures regarding the provision of culturally appropriate care to their patients (Standard 2.2.c). For agencies in compliance with Standard 2.2.c regarding culturally appropriate care (n=8), 100% report compliance with the section of the standard requiring the providers to have training or experience with caring for those groups most affected by the epidemic including gay men, African-Americans, and substance abusing persons. Eighty-two percent (82%) of the agencies reported substance abuse treatment services will be provided regardless of the sexual orientation of the clients/patients (Standard 2.2d).

There is 55% compliance with Standard 2.2.e stating that if unlicensed providers will be providing services, a formal letter of collaboration must detail the nature and type of supervision received by specific licensed providers.

**Table 21. Agency-level assessment of compliance with Standard of Care 2.2**

EMA Standard	Percent of agencies reporting compliance with Standard	
The provider organization will provide assurances and a method of protection of patient rights in the process of care provision. (Standard 2.2.a)	82%	(n=11)
The provider organization will provide assurances and a method of protection of patient confidentiality (in accordance with Maryland Annotated Code) with regard to medical information transmission, maintenance and security. (Standard 2.2.b)	73%	(n=11)
The provider organization will provide assurances regarding the provision of culturally appropriate care to their patients/clients.  Specifically, the providers must have training or experience with caring for those groups most affected by the epidemic, such as: <ul style="list-style-type: none"> <li>✖ gay men,</li> <li>✖ African-Americans</li> <li>✖ substance abusing persons.</li> </ul> (Standard 2.2.c)	<ul style="list-style-type: none"> <li>✖ gay men (100%; n=8)</li> <li>✖ African-Americans (100%; n=8)</li> <li>✖ substance abusing persons (100%; n=8)</li> </ul>	(n=11)
The provider organization will provide assurances that substance abuse treatment services will be provided regardless of the sexual orientation of the client/patient, respect, confidentiality, and equal access will be assured. (Standard 2.2.d)	82%	(n=11)
If unlicensed providers will be providing services, a formal letter of collaboration must detail the nature and type of supervision received by specific certified/licensed providers. (Standard 2.2.e)	55%	(n=11)

**C. Access, Care and Provider Continuity (Standard of Care 2.3)**

Agencies report a wide range of compliance with standards relating to access, care and provider continuity (Table 22).

Standard 2.3.a states that the provider organization must provide clinical services in a timely fashion to all patients/clients. Seventy-three percent (73%) of agencies report being in compliance with the standard including compliance with the section of the standard stating that new patient/client evaluations will generally be conducted within five working days of notification of the provider.

Eighty-two percent (82%) of agencies report they provide mechanisms for urgent care evaluation or triage (Standard 2.3.b).

High rates of compliance were reported for Standard 2.3.c which deals with access to the following services, if clinically indicated: inpatient detoxification (91%), outpatient detoxification (91%), twelve-step programs (100%), and long-term structured treatment (100%).

High rates of compliance were reported for Standard 2.3.d. which deals with the provider organization's mechanisms for continuity of substance abuse treatment to their patients/clients in all settings in which they may receive care, including, but not limited to: day programs (55%), day hospitals

(64%), mental health programs (82%), inpatient psychiatric units (73%), inpatient medical units (73%), and chronic care units (55%).

Eighty-two percent (82%) of the agencies indicate they will develop and maintain linkages with substance abuse treatment service providers in order to maintain continuity of care for patients with dual diagnoses of substance abuse disorders and other mental disorders (Standard 2.3.e).

Standard 2.3.f states that the provider organization must develop and maintain formal memorandum of understanding/agreement with case management and/or primary medical care provider to ensure continuity of care. Less than half (46%) of the agencies report that they are in compliance with the Standard as it relates to both case management and primary medical care.

**Table 22. Agency-level assessment of compliance with Standard of Care 2.3**

EMA Standard	Percent of agencies reporting compliance with Standard	
The provider organization will provide clinical services in a timely fashion to all patients/clients.	73%	(n=11)
New patient/client evaluations will generally be conducted within 5 working days of notification of the provider. (Standard 2.3.a)		
The provider organization must provide mechanisms for urgent care evaluation or triage. (Standard 2.3.b)	82%	(n=11)
The provider organization will provide mechanisms to make available to its patients/clients access, if clinically indicated, to the full range of substance abuse treatment settings including, but not limited to:		(n=11)
<ul style="list-style-type: none"> <li>✖ Detoxification (inpatient and outpatient)</li> <li>✖ Twelve-step programs</li> <li>✖ Long term structured treatment programs (e.g., half-way houses).</li> </ul> (Standard 2.3.c)	<ul style="list-style-type: none"> <li>✖ Inpatient detoxification (91%)</li> <li>✖ Outpatient detoxification (91%)</li> <li>✖ Twelve-step programs (100%)</li> <li>✖ Long term structured treatment programs (100%)</li> </ul>	
The provide organization will have a system that ensures continuity of substance abuse treatment to their patients/clients in all settings in which they may receive care, including, but not limited to:		(n=11)
<ul style="list-style-type: none"> <li>✖ Day programs</li> <li>✖ Day hospitals</li> <li>✖ Mental health programs</li> <li>✖ Inpatient psychiatric units</li> <li>✖ Inpatient medical units; and</li> <li>✖ Chronic care units (nursing homes).</li> </ul> (Standard 2.3.d)	<ul style="list-style-type: none"> <li>✖ Day programs (55%)</li> <li>✖ Day hospitals (64%)</li> <li>✖ Mental health programs (82%)</li> <li>✖ Inpatient psychiatric units (73%)</li> <li>✖ Inpatient medical units (73%)</li> <li>✖ Chronic care units (nursing homes) (55%)</li> </ul>	
The provider organization will develop and maintain linkages with mental health treatment service providers, such as to maintain care continuity for patients with dual diagnoses of substance use disorders and other mental disorders. (Standard 2.3.e)	82%	(n=11)
The provider organization must develop and maintain formal memorandum of understanding/agreement with case management and/or primary medical care provider to ensure care continuity. (Standard 2.3.f)	Case management (46%) Primary care (46%)	(n=11)

#### D. Quality Improvement (Standard of Care 2.4)

High rates of compliance were reported for the three standards dealing with quality improvement (Table 23).

All of the agencies (100%) indicate they will provide for methods to monitor areas in need of improvement (Standard 2.4.a). The agency survey instrument combined Standards 2.4.a and 2.4.b. Therefore, all of the agencies (100%) report they will provide for the development of corrective action and the assessment of the effect of such actions, regarding areas in need of improvement (Standard 2.4.b). Standard 2.4.b also states that providers must consider providing access to their staff on a 24-hour basis. Eighty-two percent (82%) of agencies reported having considered providing 24-hour access. Currently, 7 (64%) agencies offer 24-hour access. The 4 agencies that do not offer 24-hour access cite reasons such as lack of adequate staff, too few clients, or use of the emergency room. Eighty-two percent (82%) of the agencies report compliance with Standard 2.4.c, which states that utilization review decisions will be clinically based on best practice and consistent with emerging national standards.

**Table 23. Agency-level assessment of compliance with Standard of Care 2.4**

EMA Standard	Percent of agencies reporting compliance with Standard	
The provider organization will provide for methods to monitor for areas in need of improvement. (Standard 2.4.a)	100%	(n=11)
The provider organization will provide for methods for the development of corrective action and the assessment of the effect of such actions, regarding areas in need of improvement.		(n=11)
Providers must consider providing access to their staff on a 24-hour basis. (Standard 2.4.b)	82% have considered providing 24-hour access	
Utilization review decisions will be clinically based on best practice and consistent with emerging national standards. (Standard 2.4.c)	82%	(n=11)

## Section 5. Discussion

The QIP process provided a systematic review of compliance to the EMA's Standards of Care for 100% of the substance abuse treatment providers (n=9) receiving Title I funds during FY2001. While there are nine agencies directly receiving funds, one of those agencies subcontracts with an additional three organizations that provide substance abuse treatment services. A total of 217 substance abuse treatment client records were reviewed, representing 18.7% of the Title I substance abuse treatment clients served in the Baltimore EMA.

The following items have a higher rate of compliance with the Standards of Care:

- ✦ Eighty-one percent (81%) of clients who initiated services during the review period had an initial evaluation completed.
- ✦ Eighty-seven percent (87%) of records reviewed with an initial evaluation documented a client history.
- ✦ Seventy-six percent (76%) of clients who initiated services during the review period contained a formal plan of care. Of these, 80% of the care plans contained specific measurable treatment goals and 78% documented client input into the care plan.
- ✦ Eighty-one percent (81%) of clients had visit frequencies that were appropriate based on diagnosis, severity of need, and treatment plan.
- ✦ Sixty-five percent (65%) of the records reviewed documented that supportive and educational counseling was provided at all visits.
- ✦ The 11 agencies provide a large number of services to clients in addition to substance abuse treatment services. These services are provided directly as well as by referral.
- ✦ Overall, the agencies report relatively high rates of compliance with all of the Standards relating to agency policies and procedures regarding licensing, knowledge, skills and experience.
- ✦ With one exception, agencies report a relatively high degree of compliance with Standards relating to patient rights and confidentiality. A higher degree of compliance was reported for Standards related to quality improvement.

This review of QIP data identifies several areas where there is a lower rate of compliance with the Standards of Care. The most notable areas are discussed below and include:

1. Initial client evaluations;
2. Development and reassessment of treatment plans;
3. Patient counseling and education; and
4. Linkages/continuity of care.

In respect to initial evaluations, over 80% of the clients who initiated substance abuse services during the review period received an initial evaluation. Of those that had an evaluation completed, 87% had a client history documented. However, other components of the initial evaluation had lower rates of completion. Less than half (47%) had either a mental status evaluation or a cognitive assessment

completed and 24% had the Addiction Severity Index (ASI) completed. Less than half (49%) had a multi-axial differential diagnosis documented and only 40% documented the patient's current or recent medication regimen. In all records reviewed, CD4 counts and viral loads were not consistently documented; 55% and 36%, respectively.

Treatment plans were not consistently developed by the agencies surveyed. Sixty-eight percent (68%) of the records reviewed documented formal treatment plans. A larger number (76%) of treatment plans were documented for clients who had an initial evaluation conducted during the review period. Once in place, treatment plans were not assessed as specified by the Standards. Only 41% of the records documented appropriate re-evaluation of the plan.

Although 65% of the reviewed records documented the provision of supportive and educational counseling, as part of Standard 1.2.b counseling should also address HIV prevention. Only 30% of the records documented HIV prevention counseling. While more than half of the clients were receiving medication (58%), side effect monitoring was noted in only 55% of the records. Patient education about medications was documented in only 28% of the records.

In respect to linkages and continuity of care, less than one-half of agencies report having formal memorandum of understanding/agreement with case management and primary medical care providers. Additionally, 39% of the applicable records reviewed documented appropriate discharge planning. Of the records reviewed, less than a quarter documented issues related to the client's HIV-related care and/or status.

## Section 6. Recommendations

The primary recommendations for Substance Abuse Treatment Services focus on three areas: 1) priority areas for quality improvement projects; 2) review and revision of the Standards of Care; and 3) development of quality indicators for Substance Abuse Treatment Services.

### Priority Areas for Quality Improvement Projects

As previously identified, the most notable issues related to the provision of Substance Abuse Treatment Services focus on four main areas: 1) initial client evaluations; 2) development and reassessment of treatment plans; 3) patient counseling and education; and 4) linkages/continuity of care. As the EMA and individual vendors identify quality improvement projects to undertake, these four areas can be incorporated into these projects.

### Review and Revision of the Standards of Care

As an initial step in the quality improvement process, it might be beneficial to review the Standards of Care to clarify the minimum expectations of service delivery, identify components that are not currently addressed and revise them as appropriate. Within the currently published Standards, specific examples of items that are not currently addressed in the Standards include the following: 1) discharge planning; 2) documentation of failed/cancelled or missed appointments; 3) follow-up of clients lost to care; and 4) policies and procedures for termination or closing of cases.

The Standards should also specify the client-level data providers should be expected to document not only as part of the initial assessment but also to regularly update. These include:

- ✦ HIV-transmission risk
- ✦ CD4 value
- ✦ Viral load
- ✦ Current medications, including antiretroviral therapy
- ✦ Current primary medical care provider
- ✦ Case manager/case management agency
- ✦ Insurance status

Additionally, it may be beneficial to expand the routine reporting requirements to include type of treatment modalities provided and more client-specific utilization data that can be used to monitor trends.

### Quality Indicators

As the Standards are revised, incorporation of quality indicators is integral to the quality improvement process. By identifying the core indicators to track and trend, the expectations regarding service delivery are further clarified. Based on the review of the Standards and the data collected as part of the QIP review process, the recommended core quality indicators to track as part of Substance Abuse Treatment Services are identified in Table 23. Target performance goals have also been identified in this table, but the actual goal should be finalized in conjunction with BCHD and the Planning Council.

Table 24. Recommended Quality Indicators for Substance Abuse Treatment Services

Quality Indicator [Reference]	EMA Mean Performance	Performance Goal
% of client records which document completion of initial evaluation prior to the initiation of treatment. [Standard 1.1]	81%	90%
% of client records which document completion of Addiction Severity Index (ASI) or the Problem Oriented Screening Instrument for Teenagers (POSIT) [Standard 1.1.d; National Quality Measures Clearinghouse <sup>4</sup> ]	24%	80%
% of client records which document completion of treatment plan [with specific measurable treatment goals through the appropriate use of outcome assessment] [Standard 1.1.g]	76%	90%
% of client records which document reassessment of the treatment plan and progress every three months. [Standard 1.2.f]	8%	80%
% of client records which document provision of counseling regarding the prevention of HIV-transmitting behaviors and substance abuse. [Standard 1.2.e]	64%	80%

<sup>4</sup> The Agency for Healthcare Research and Quality, Center for Quality Measures is a public repository for evidence-based quality measures and measure sets. A search of the keyword “substance abuse” resulted in a single reference to the Veteran’s Administration’s measure: Substance abuse: percent of patients in a specialized substance abuse program who have an initial addiction severity index (ASI). Veterans Health Administration. 2002 Mar. NQMC:000048. Accessed at: <http://www.qualitymeasures.ahrq.gov>

## **Appendices**

- ✦ Appendix A. Summary of Multi-Axial Diagnoses
- ✦ Appendix B. Client Chart Abstraction Instrument: Substance Abuse Treatment Services
- ✦ Appendix C. Agency Survey: Substance Abuse Treatment Services
- ✦ Appendix D. Operational and Performance Standards for Substance Abuse Treatment Providers, ratified August 2001. Greater Baltimore HIV Health Services Planning Council.  
<http://www.baltimorepc.org>

## Appendix A. Summary of multi-axial Diagnoses

The tables below show the frequencies of diagnoses by Axis. The most frequent Axis 1 diagnoses are: opioid dependence, cocaine dependence, alcohol dependence and cocaine abuse.

#	DSM-IV Code	Axis 1 Diagnosis
25	304	Opioid Dependence
21	304.2	Cocaine Dependence
14	303.9	Alcohol Dependence
10	305.6	Cocaine Abuse
9	304.4	Amphetamine Dependence
5	305	Alcohol Abuse
5	305.1	Nicotine Dependence
5	304.1	Sedative, Hypnotic, or Anxiolytic Dependence
3	311	Depressive Disorder NOS (Not otherwise specified)
3	304.8	Polysubstance Dependence
2	305.7	Amphetamine Abuse
2	296.8	Bipolar Disorder NOS
2	305.2	Cannabis Abuse
2	304.3	Cannabis Dependence
2	300.4	Dysthymic Disorder
2	298.9	Psychotic Disorder NOS
1	309.28	Adjustment Disorder With Mixed Anxiety and Depressed Mood
1	300	Anxiety Disorder NOS
1	296.55	Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission
1	296.52	Bipolar I Disorder, Most Recent Episode Depressed, Moderate
1	304.9	Other (or Unknown) Substance Dependence
1	309.81	Posttraumatic Stress Disorder

Note: Multiple responses documented.

As noted in the text, few clients with a documented multi-axial diagnosis had an Axis 2 diagnosis.

#	DSM-IV Code	Axis 2 Diagnosis
14	V71.09	No Diagnosis on Axis II
2	301.7	Antisocial Personality Disorder
2	301.83	Borderline Personality Disorder
1	296.8	Bipolar Disorder NOS
1	311	Depressive Disorder NOS
1	301.81	Narcissistic Personality Disorder

Note: Multiple responses documented.

HIV/AIDS and hepatitis were the most frequently documented Axis 3 diagnosis.

#	Axis 3 Diagnosis
39	HIV/AIDS
9	Hepatitis
7	Hypertension
4	Bronchitis
3	medical

2	Asthma
2	Peripheral neuropathy
1	Anemia
1	Chronic pain
1	Colon Cancer
1	Diabetes
1	Herpes
1	Pregnancy
1	Seizure disorder
1	Spinal fracture

Note: Multiple responses documented.

Problems with primary support group and occupational problems were the most frequently documented Axis 4 diagnosis.

#	Axis 4 Diagnosis
17	Problems with primary support group
17	Occupational problems
14	Economic problems
11	Housing problems
10	Problems with access to health care services
10	Other psychosocial and environmental problems
5	Problems related to the social environment
5	Problems related to interaction with the legal system/crime
3	Educational problems

# **BCHD Quality Improvement Project Substance Abuse Treatment Services Client Chart Abstraction**

## **Section 1. Reviewer Information**

Instructions: Complete the requested information.

1.1	Date of review	
1.2	Name of reviewer	
1.3	Client chart ID#	
1.4	Time start chart review	
1.5	Time end chart review	
1.6	Total time for chart review (hrs:min)	
1.7	Chart start date (Date of first entry in client chart)	
1.8	Chart end date (Date of last entry in client chart)	
1.9	Dates of services reviewed in chart	<input type="checkbox"/> 3/1/01 to 2/28/02 (Default)  ____ / ____ / ____ to ____ / ____ / ____
1.10	Was chart <b>opened/substance abuse services initiated</b> during review period?	<input type="checkbox"/> Yes <input type="checkbox"/> No; substance abuse services initiated prior to review period <input type="checkbox"/> Not documented in chart
1.11	Was <b>chart closed/client terminated</b> from substance abuse services during review period?	<input type="checkbox"/> Yes <input type="checkbox"/> No; client continued to receive substance abuse services throughout review period <input type="checkbox"/> Not documented in chart

## Section 2. Client Demographics

**Instructions:** Provide the requested information based on information contained in the client's chart.

2.1 Date of birth	____ / ____ / ____  <input type="checkbox"/> Age on 2/28/02 if no dob in chart ____ <input type="checkbox"/> Not documented in chart
2.2 Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Not documented in chart
2.3 Race/Ethnicity	<input type="checkbox"/> White <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino/a <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> African <input type="checkbox"/> Caribbean <input type="checkbox"/> Other: Specify: <input type="checkbox"/> Not documented in chart
2.4 HIV risk factor <i>[Check all that apply]</i>	<input type="checkbox"/> Men who have sex with men (MSM) <input type="checkbox"/> Injecting drug user (IDU) <input type="checkbox"/> MSM and IDU <input type="checkbox"/> Heterosexual contact <input type="checkbox"/> Heterosexual contact and IDU <input type="checkbox"/> Hemophilia/coagulation disease or receipt of blood products <input type="checkbox"/> Undetermined/unknown, risk not reported <input type="checkbox"/> Perinatal transmission <input type="checkbox"/> Other: Specify:  <input type="checkbox"/> Not documented in chart
2.5 Zip code client residing in on 3/1/01 (or first entry In review period)	_____  City, if no zip code indicated:  <input type="checkbox"/> Not documented in chart

<p>2.6.a Client health insurance on 3/1/01 (or first entry in review period)</p> <p><i>[Check all that apply]</i></p>	<p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Medicaid &lt;See list of Medicaid MCOs&gt;</p> <p><input type="checkbox"/> CHIPS</p> <p><input type="checkbox"/> Maryland AIDS Drug Assistance Program</p> <p><input type="checkbox"/> Maryland Pharmacy Assistance Program</p> <p><input type="checkbox"/> Maryland Primary Care Program</p> <p><input type="checkbox"/> Medicare</p> <p><input type="checkbox"/> Private/Commercial</p> <p><input type="checkbox"/> Veteran's Administration</p> <p><input type="checkbox"/> Corrections</p> <p><input type="checkbox"/> Unknown [client reports not knowing]</p> <p><input type="checkbox"/> Other: Specify:</p> <p><input type="checkbox"/> Not documented in chart</p>	<p>List of Maryland's HealthChoice Medicaid MCOs</p> <hr/> <p>AMERICAID Community Care</p> <p>Helix Family Choice</p> <p>Jai Medical Systems</p> <p>Maryland Physicians Care</p> <p>Priority Partners</p> <p>United HealthCare</p>
<p>2.6.b Client health insurance on 2/28/02 (or last entry in review period)</p> <p><i>[Check all that apply]</i></p>	<p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Medicaid &lt;See list of Medicaid MCOs&gt;</p> <p><input type="checkbox"/> CHIPS</p> <p><input type="checkbox"/> Maryland AIDS Drug Assistance Program</p> <p><input type="checkbox"/> Maryland Pharmacy Assistance Program</p> <p><input type="checkbox"/> Maryland Primary Care Program</p> <p><input type="checkbox"/> Medicare</p> <p><input type="checkbox"/> Private/Commercial</p> <p><input type="checkbox"/> Veteran's Administration</p> <p><input type="checkbox"/> Corrections</p> <p><input type="checkbox"/> Unknown [client reports not knowing]</p> <p><input type="checkbox"/> Other: Specify:</p> <p><input type="checkbox"/> Not documented in chart</p>	
<p>2.7.a HIV-disease status on 3/1/01 (or first entry in review period)</p>	<p><input type="checkbox"/> HIV-positive, not AIDS Date of dx: ____/____/____ <input type="checkbox"/> Date not documented in chart</p> <p><input type="checkbox"/> CDC defined AIDS Date of dx: ____/____/____ <input type="checkbox"/> Date not documented in chart</p> <p><input type="checkbox"/> Not documented in chart</p>	
<p>2.7.b HIV-disease status on 2/28/02 (or last entry in review period)</p>	<p><input type="checkbox"/> Deceased Date of death: ____/____/____ <input type="checkbox"/> Date not documented in chart</p> <p><input type="checkbox"/> HIV-positive, not AIDS Date of dx: ____/____/____ <input type="checkbox"/> Date not documented in chart</p> <p><input type="checkbox"/> CDC defined AIDS Date of dx: ____/____/____ <input type="checkbox"/> Date not documented in chart</p> <p><input type="checkbox"/> Not documented in chart</p>	

2.8.a CD4/Viral Load 3/1/01 (or first entry in review period)	CD4 _____ cells/uL Date of test: ____/____/____ <input type="checkbox"/> Date not documented in chart  Viral load: _____ Date of test: ____/____/____ <input type="checkbox"/> Date not documented in chart <input type="checkbox"/> Not documented in chart	<div style="border: 1px solid black; padding: 5px;"> <b>④ Source:</b>  <input type="checkbox"/> Documented patient self report  <input type="checkbox"/> Copy of lab report in chart  <input type="checkbox"/> Communication from medical provider (e.g., letter, medical encounter progress note)  <input type="checkbox"/> Patient flow sheet in chart  <input type="checkbox"/> Other/Specify         </div>
2.8.b CD4/Viral Load 2/28/02 (or last entry in review period)	CD4 _____ cells/uL Date of test: ____/____/____ <input type="checkbox"/> Date not documented in chart  Viral load: _____ Date of test: ____/____/____ <input type="checkbox"/> Date not documented in chart <input type="checkbox"/> Not documented in chart	<div style="border: 1px solid black; padding: 5px;"> <b>④ Source:</b>  <input type="checkbox"/> Documented patient self report  <input type="checkbox"/> Copy of lab report in chart  <input type="checkbox"/> Communication from medical provider (e.g., letter, medical encounter progress note)  <input type="checkbox"/> Patient flow sheet in chart  <input type="checkbox"/> Other/Specify         </div>
2.9.a Client on HAART 3/1/01 (or first entry in review period)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Treatment not documented in chart  <div style="border: 1px solid black; padding: 5px;"> <b>④ Source:</b>  <input type="checkbox"/> Documented patient self report  <input type="checkbox"/> Copy of medication sheet from medical provider  <input type="checkbox"/> List of medications maintained by case manager  <input type="checkbox"/> Communication from medical provider (e.g., letter, medical encounter progress note)  <input type="checkbox"/> Other/Specify         </div>	
2.9.b Client on HAART 2/28/02 (or last entry in review period)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Treatment not documented in chart  <div style="border: 1px solid black; padding: 5px;"> <b>④ Source:</b>  <input type="checkbox"/> Documented patient self report  <input type="checkbox"/> Copy of medication sheet from medical provider  <input type="checkbox"/> List of medications maintained by case manager  <input type="checkbox"/> Communication from medical provider (e.g., letter, medical encounter progress note)  <input type="checkbox"/> Other/Specify         </div>	

### Section 3. Initial Evaluation

**Instructions:** This section is to be completed only for clients who had an initial evaluation completing during the review period—March 1, 2001 to February 28, 2002.

- ☐ Initial evaluation completed before March 1, 2001 **▶ GO TO Section 4.0, p. 10**
- ☐ Client initiated substance abuse services after March 1, 2001 [and before February 28, 2002], but initial evaluation was not completed. **▶ GO TO Section 4.0, p. 10**
- ☐ Initial evaluation completed after March 1, 2001 [and before February 28, 2002].

❶ Date of referral for services: \_\_\_\_\_

❷ Referral made by:

- ☐ Agency/specify:  
☐ Self  
☐ Family  
☐ Criminal justice system  
☐ Child welfare system  
☐ Other/Specify

☐ Source of referral not documented in chart:

❸ Date evaluation began	❹ Date completed
<input type="checkbox"/> Chart does not provide this information.	<input type="checkbox"/> Chart does not provide this information.

	Review Item	Documentation												
3.a	Initial evaluation must be conducted prior to the initiation of treatment. <i>[SA Standard 1.1]</i>	<input type="checkbox"/> Yes, chart contains evidence that initial evaluation was completed prior to treatment initiation. <input type="checkbox"/> Evaluation completed after treatment initiated. <input type="checkbox"/> No evaluation was completed. <b>▶ GO TO Section 4.0, p. 10</b> <input type="checkbox"/> Other/Specify:												
3.b	Initial evaluation must be conducted by clinical staff who are knowledgeable about the full spectrum of drug addiction. <i>[SA Standard 1.1]</i>	<input type="checkbox"/> Yes, chart contains evidence that standard was met. <input type="checkbox"/> No, chart does not contain evidence that standard was met.												
3.c	Initial evaluation documents client history <i>[SA Standard 1.1.a]</i>	<input type="checkbox"/> Yes, chart contains evidence that evaluation documents client history.  ▶ Check areas documented in client history: <table><tr><td><input type="checkbox"/> Chief complaint</td><td><input type="checkbox"/> Review of systems</td></tr><tr><td><input type="checkbox"/> Current substance abuse history</td><td><input type="checkbox"/> Current and recent medications</td></tr><tr><td><input type="checkbox"/> Past substance abuse history</td><td><input type="checkbox"/> Premorbid personality</td></tr><tr><td><input type="checkbox"/> Family history</td><td><input type="checkbox"/> Medical history</td></tr><tr><td><input type="checkbox"/> Past psychiatric history</td><td><input type="checkbox"/> Review of systems</td></tr><tr><td><input type="checkbox"/> Social and personal history</td><td><input type="checkbox"/> Current and recent medications</td></tr></table> <input type="checkbox"/> No, chart does not document a client history.	<input type="checkbox"/> Chief complaint	<input type="checkbox"/> Review of systems	<input type="checkbox"/> Current substance abuse history	<input type="checkbox"/> Current and recent medications	<input type="checkbox"/> Past substance abuse history	<input type="checkbox"/> Premorbid personality	<input type="checkbox"/> Family history	<input type="checkbox"/> Medical history	<input type="checkbox"/> Past psychiatric history	<input type="checkbox"/> Review of systems	<input type="checkbox"/> Social and personal history	<input type="checkbox"/> Current and recent medications
<input type="checkbox"/> Chief complaint	<input type="checkbox"/> Review of systems													
<input type="checkbox"/> Current substance abuse history	<input type="checkbox"/> Current and recent medications													
<input type="checkbox"/> Past substance abuse history	<input type="checkbox"/> Premorbid personality													
<input type="checkbox"/> Family history	<input type="checkbox"/> Medical history													
<input type="checkbox"/> Past psychiatric history	<input type="checkbox"/> Review of systems													
<input type="checkbox"/> Social and personal history	<input type="checkbox"/> Current and recent medications													

<p>3.d Initial evaluation documents mental status evaluation [SA Standard 1.1.b]</p>	<p><input type="checkbox"/> Yes, chart contains evidence that evaluation documents mental status.</p> <p>▶ Check areas documented in mental status evaluation:</p> <p><input type="checkbox"/> Appearance  <input type="checkbox"/> Behavior  <input type="checkbox"/> Talk  <input type="checkbox"/> Mood  <input type="checkbox"/> Vital sense  <input type="checkbox"/> Self attitude  <input type="checkbox"/> Suicidal risk  <input type="checkbox"/> Homicidal risk  <input type="checkbox"/> Abnormal beliefs  <input type="checkbox"/> Perceptual disturbances  <input type="checkbox"/> Obsessions/compulsions, phobias and panic attacks</p> <p><input type="checkbox"/> No, chart does not document a mental status evaluation.</p>															
<p>3.e Initial evaluation documents cognitive assessment [SA Standard 1.1.c]</p>	<p><input type="checkbox"/> Yes, chart contains evidence that evaluation documents cognitive assessment.</p> <p>▶ Check areas documented in cognitive assessment:</p> <p><input type="checkbox"/> Level of consciousness  <input type="checkbox"/> Orientation  <input type="checkbox"/> Memory  <input type="checkbox"/> Language  <input type="checkbox"/> Mini-Mental Status and Verbal Trails Test ▶ Score: _____</p> <p><input type="checkbox"/> No, chart does not document a cognitive assessment</p>															
<p>3.f Initial evaluation documents severity assessment. [SA Standard 1.1.d]</p>	<p><input type="checkbox"/> Yes, chart contains evidence that evaluation documents severity.</p> <p>▶ Check instrument used/score</p> <p><input type="checkbox"/> Addiction Severity Index ▶ Score: _____  <input type="checkbox"/> Problem Oriented Screening Instrument for Teenagers ▶ Score: _____  Other/Specify: _____</p> <p><input type="checkbox"/> No, chart does not document severity assessment by the identified instrument.</p>															
<p>3.g Initial evaluation documents laboratory studies, as indicated. [SA Standard 1.1.e]</p>	<p><input type="checkbox"/> Yes, chart contains evidence that evaluation documents laboratory studies, as indicated.  <input type="checkbox"/> No, chart does not contain evidence that standard was met.</p> <p><b>Check whether laboratory study was clinically indicated for patient and whether it was performed during the initial evaluation.</b></p> <table border="1" data-bbox="609 1549 1344 1856"> <thead> <tr> <th>Study</th> <th>Indication</th> <th>Performed</th> </tr> </thead> <tbody> <tr> <td>Blood Alcohol</td> <td><input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Toxicologies: Cannabinoids</td> <td><input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Toxicologies: Cocaine</td> <td><input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Toxicologies: Opioids</td> <td><input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </tbody> </table> <p style="text-align: right;">cont. ➞</p>	Study	Indication	Performed	Blood Alcohol	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No	Toxicologies: Cannabinoids	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No	Toxicologies: Cocaine	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No	Toxicologies: Opioids	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No
Study	Indication	Performed														
Blood Alcohol	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Toxicologies: Cannabinoids	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Toxicologies: Cocaine	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No														
Toxicologies: Opioids	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No														

	<p>← cont.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: black; color: white;"> <th style="text-align: left;">Study</th> <th style="text-align: left;">Indication</th> <th style="text-align: left;">Performed</th> </tr> </thead> <tbody> <tr> <td>Toxicologies:</td> <td><input type="checkbox"/> Indicated</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Amphetamines</td> <td><input type="checkbox"/> Not indicated</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Toxicologies:</td> <td><input type="checkbox"/> Indicated</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td>Other/Specify:</td> <td><input type="checkbox"/> Not indicated</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Liver Panel</td> <td><input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Renal Panel</td> <td><input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Thyroid Function</td> <td><input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>B-12/Folate</td> <td><input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Medication Levels</td> <td><input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Other/Specify</td> <td><input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </tbody> </table>	Study	Indication	Performed	Toxicologies:	<input type="checkbox"/> Indicated	<input type="checkbox"/> Yes	Amphetamines	<input type="checkbox"/> Not indicated	<input type="checkbox"/> No	Toxicologies:	<input type="checkbox"/> Indicated	<input type="checkbox"/> Yes	Other/Specify:	<input type="checkbox"/> Not indicated	<input type="checkbox"/> No	Liver Panel	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Panel	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Function	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No	B-12/Folate	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication Levels	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other/Specify	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No
Study	Indication	Performed																																
Toxicologies:	<input type="checkbox"/> Indicated	<input type="checkbox"/> Yes																																
Amphetamines	<input type="checkbox"/> Not indicated	<input type="checkbox"/> No																																
Toxicologies:	<input type="checkbox"/> Indicated	<input type="checkbox"/> Yes																																
Other/Specify:	<input type="checkbox"/> Not indicated	<input type="checkbox"/> No																																
Liver Panel	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No																																
Renal Panel	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No																																
Thyroid Function	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No																																
B-12/Folate	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No																																
Medication Levels	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No																																
Other/Specify	<input type="checkbox"/> Indicated <input type="checkbox"/> Not indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No																																
<p>3.h Initial evaluation documents multi-axial differential diagnosis leading to final diagnostic formulation, with special emphasis of co-morbid mental disorders <i>[SA Standard 1.1.f]</i></p> <p><i>See Instrument Instructions for DSM-IV listings</i></p> <p>Axis I: Clinical disorders; other conditions that may be a focus of clinical attention            Axis II: Personality disorders; mental retardation            Axis III: General medical conditions            Axis IV: Psychosocial and environmental problems            Axis V: Global Assessment of Functioning (GAF)            100-91: Superior            90-81: Absent/minimal            80-71: Transient/expectable            70-61: Mild symptoms            60-51: Moderate symptoms            50-41: Serious symptoms            40-31: Some/major impairment in several areas            30-21: Delusions/hallucinations; inability to function in most areas            20-11: Some danger of hurting self/others; occasionally fails to maintain personal hygiene; inability to function in all areas            10-1: Persistent danger of severely hurting self or others; persistent inability to maintain personal hygiene; or serious suicidal act with clear expectation of death</p>	<p>❶ Does chart document a multi-axial diagnosis consistent with initial evaluation findings?  <input type="checkbox"/> Yes, chart does document a multi-axial diagnosis developed from evaluation data.  <input type="checkbox"/> No, chart does not document a multi-axial diagnosis developed from evaluation data.</p> <p>Documented diagnosis:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Axis I:</td></tr> <tr><td>Axis II:</td></tr> <tr><td>Axis III:</td></tr> <tr><td>Axis IV:</td></tr> <tr> <td>Axis V: ▶ Current GAF:</td> <td style="text-align: right;"><input type="checkbox"/> GAF not documented</td> </tr> <tr> <td>▶ Highest GAF in prev. 12 months:</td> <td style="text-align: right;"><input type="checkbox"/> GAF not documented</td> </tr> </table> <p>❷ Does chart document the identification of co-morbid mental disorders?  <input type="checkbox"/> Yes. Client assessed, and determined to have co-morbid mental disorders.              ▶ Specify co-morbid mental disorders:</p> <p><input type="checkbox"/> No. Client assessed, but determined not to have any co-morbid mental disorders.  <input type="checkbox"/> Chart does not contain documentation that assessment was made regarding co-morbid mental disorders.</p>	Axis I:	Axis II:	Axis III:	Axis IV:	Axis V: ▶ Current GAF:	<input type="checkbox"/> GAF not documented	▶ Highest GAF in prev. 12 months:	<input type="checkbox"/> GAF not documented																									
Axis I:																																		
Axis II:																																		
Axis III:																																		
Axis IV:																																		
Axis V: ▶ Current GAF:	<input type="checkbox"/> GAF not documented																																	
▶ Highest GAF in prev. 12 months:	<input type="checkbox"/> GAF not documented																																	

<p>3.i Development of treatment plan with specific measurable treatment goals through the appropriate use of outcome assessment.</p> <ul style="list-style-type: none"> <li>▶ The treatment plan must address the full range of substances the patient is abusing.</li> <li>▶ The treatment plan must include input from the patient.</li> </ul> <p>[SA Standard 1.1.g]</p>	<p><b>1</b> Does chart contain a treatment plan developed from the data collected during the initial evaluation?</p> <p><input type="checkbox"/> No, chart does not contain a treatment plan developed from initial evaluation data.</p> <p style="padding-left: 40px;">▶ <b>GO TO Section 4.0, p. 10</b></p> <p><input type="checkbox"/> Yes, chart contains a treatment plan developed from initial evaluation data.</p> <p style="padding-left: 40px;">▶ <b>CONTINUE</b></p> <p><b>2</b> Does treatment plan contain specific, measurable treatment goals?</p> <p><input type="checkbox"/> Yes, treatment plan contains specific, measurable treatment goals.</p> <p><input type="checkbox"/> No, treatment plan does not contain specific, measurable treatment goals.</p> <p><b>3</b> Does treatment plan contain method of outcome assessment to be used?</p> <p><input type="checkbox"/> Yes, treatment plan contains method of outcome assessment to be used.</p> <p><input type="checkbox"/> No, treatment plan does not contain method of outcome assessment to be used.</p> <p><b>4</b> Does treatment plan specify frequency of follow-up visits?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><b>5</b> Does treatment plan address issues relating to patient's HIV-related care and/or status?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><b>6</b> Does treatment plan address the full range of substances the patient is abusing?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p style="padding-left: 40px;">▶ Check limitations of plan:</p> <p style="padding-left: 80px;"><input type="checkbox"/> Only primary substance/"drug of choice" is addressed.</p> <p style="padding-left: 80px;"><input type="checkbox"/> Only illicit substances are addressed.</p> <p><b>7</b> Does treatment plan address other issues of concern to the patient (e.g., need for housing, employment, medical care?)</p> <p><input type="checkbox"/> Yes:</p> <p style="padding-left: 40px;">▶ Check how treatment plan addresses these issues:</p> <p style="padding-left: 80px;"><input type="checkbox"/> Treatment plan contains specific goals/outcomes relating to these issues for mental health services provider to address.</p> <p style="padding-left: 80px;"><input type="checkbox"/> Treatment plan indicates referral/collaboration with a case manager to address these issues.</p> <p><input type="checkbox"/> No, treatment plan addresses only the identified substance abuse related issue.</p> <p><input type="checkbox"/> Other/Specify</p> <p><b>8</b> Does treatment plan document input from the patient?</p> <p><input type="checkbox"/> Yes</p> <p style="padding-left: 40px;">▶ Check how patient input is documented:</p> <p style="padding-left: 80px;"><input type="checkbox"/> Client signed treatment plan.</p> <p style="padding-left: 80px;"><input type="checkbox"/> Provider's progress notes indicate discussion with patient.</p> <p style="padding-left: 80px;"><input type="checkbox"/> Other/Specify</p> <p><input type="checkbox"/> No, patient input is not documented.</p>
---	---

3.j **Plan of care**

Specify all modalities of treatment included in the treatment plan:

a) Modality	b) Provider (Note: "by agency" refers to agency being reviewed; note external agency client was referred to, when applicable.)	c) Date Service Began*	d) Check if terminated during review period/Date of termination
<input type="checkbox"/> Detoxification ▶ Length: ▶ Setting:	<input type="checkbox"/> By agency <input type="checkbox"/> By referral to:		<input type="checkbox"/>
<input type="checkbox"/> Psychiatric Treatment	<input type="checkbox"/> By agency <input type="checkbox"/> By referral to:		<input type="checkbox"/>
<input type="checkbox"/> Counseling/Individual	<input type="checkbox"/> By agency <input type="checkbox"/> By referral to:		<input type="checkbox"/>
<input type="checkbox"/> Individual/Psychodynamic	<input type="checkbox"/> By agency <input type="checkbox"/> By referral to:		<input type="checkbox"/>
<input type="checkbox"/> Counseling/Group	<input type="checkbox"/> By agency <input type="checkbox"/> By referral to:		<input type="checkbox"/>
<input type="checkbox"/> Counseling/Family	<input type="checkbox"/> By agency <input type="checkbox"/> By referral to:		<input type="checkbox"/>
<input type="checkbox"/> Self-Help Group	<input type="checkbox"/> By agency <input type="checkbox"/> By referral to:		<input type="checkbox"/>
<input type="checkbox"/> Methadone <input type="checkbox"/> LAAM <input type="checkbox"/>	<input type="checkbox"/> By agency <input type="checkbox"/> By referral to:		<input type="checkbox"/>
<input type="checkbox"/> Emergency Treatment (e.g., withdrawal, intoxication, psychosis, suicide)	<input type="checkbox"/> By agency <input type="checkbox"/> By referral to:		<input type="checkbox"/>
<input type="checkbox"/> Residential Treatment Program	<input type="checkbox"/> By agency <input type="checkbox"/> By referral to:		<input type="checkbox"/>
<input type="checkbox"/> Other/Specify	<input type="checkbox"/> By agency <input type="checkbox"/> By referral to:		<input type="checkbox"/>

\*If service was not provided, then write "NOT PROVIDED"; note reason service was not provided, if documented.

3.k Plan of care is consistent with practice guidelines  
[SA Standard 1.1.h]

Is the outlined plan of care consistent with guidelines for substance use disorders?

☐ Yes☐ No

Specify how the plan of care is not consistent with guidelines?

## Section 4. Provision of Services

**Instructions:** This section is to be completed for all clients. Instructions: Review only documentation of services provided during the review period, March 1, 2001 to February 28, 2002.

► This section is to be completed for all clients

4.a Treatment plan	<p>Does chart contain a treatment plan for the client?</p> <p><input type="checkbox"/> Yes, chart contains a treatment plan.</p> <p><input type="checkbox"/> No, chart does not contain a treatment plan.</p> <p><input type="checkbox"/> Other/Specify:</p>
4.b Documentation of frequency of visits [SA Standard 1.2.a]	<p>❶ Does chart contain documentation of patient visits?</p> <p><input type="checkbox"/> Yes, chart <b>does</b> contain documentation of patient visits. (e.g., progress notes/encounter data for each patient visit to provider.)</p> <p><input type="checkbox"/> No, chart <b>does not</b> contain documentation of patient visits.</p> <p>❷ Does chart contain documentation of visit frequency that is appropriate, based on the diagnosis, severity of need and treatment plan?</p> <p><input type="checkbox"/> Yes, chart <b>does</b> contain documentation of visit frequency that is based on diagnosis, severity of need, and treatment plan.</p> <p><input type="checkbox"/> No, chart <b>does not</b> contain documentation of visit frequency that is based on diagnosis, severity of need, and treatment plan.</p>
4.c Documentation of provision of supportive and educational counseling at all visits. "This should include counseling regarding the prevention of HIV-transmitting behaviors and substance abuse." [SA Standard 1.2.b]	<p>❶ Supportive and educational counseling</p> <p><input type="checkbox"/> Yes, chart <b>does</b> contain documentation of provision of supportive and educational counseling on each visit.</p> <p><input type="checkbox"/> No, chart <b>does not</b> contain documentation of provision of supportive and educational counseling on each visit.</p> <p>❷ HIV Prevention counseling</p> <p><input type="checkbox"/> Yes, chart <b>does</b> contain documentation of provision counseling regarding prevention of "HIV transmitting behaviors."</p> <p><input type="checkbox"/> No, chart <b>does not</b> contain documentation of provision counseling regarding prevention of "HIV transmitting behaviors."</p> <p>❸ Substance abuse counseling</p> <p><input type="checkbox"/> Yes, chart <b>does</b> contain documentation of provision counseling regarding substance abuse."</p> <p><input type="checkbox"/> No, chart <b>does not</b> contain documentation of provision counseling regarding substance abuse."</p>
4.d Documentation of provision of group psychotherapy or counseling as indicated by the clinical situation based on practice guideline recommendations and linked to treatment goals. [SA Standard 1.2.e]	<p><input type="checkbox"/> Yes, chart <b>does</b> contain documentation of provision of group psychotherapy or counseling as indicated by the clinical situation based on practice guideline recommendations and linked to treatment goals</p> <p><input type="checkbox"/> No, chart <b>does not</b> contain documentation of group psychotherapy or counseling as indicated by the clinical situation based on practice guideline recommendations and linked to treatment goals</p>
4.e Documentation of monitoring of medications [SA Standard 1.2.c]	<p>❶ Are medications prescribed by the substance abuse services provider?</p> <p><input type="checkbox"/> No. ► Go To: 4.g</p> <p><input type="checkbox"/> Yes ► CONTINUE</p> <p style="text-align: right;"><i>This question (4.e) continues on next page. ➞</i></p>

	<p><b>2</b> Are the medications prescribed by:</p> <p><input type="checkbox"/> Physician</p> <p><input type="checkbox"/> Psychiatrist</p> <p><input type="checkbox"/> Nurse Practitioner</p> <p><input type="checkbox"/> Physician Assistant</p> <p><input type="checkbox"/> Other/Specify</p> <p><input type="checkbox"/> Information not provided.</p> <p><b>3</b> Are medications prescribed by the substance abuse treatment provider clinically appropriate and indicated by treatment guidelines?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><b>4</b> Does chart contain documentation of routine and appropriate monitoring of medications under the supervision of a physician?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> Indicate methods used (check all that apply):</p> <p><input type="checkbox"/> Laboratory monitoring</p> <p><input type="checkbox"/> Patient interview</p> <p><input type="checkbox"/> Patient survey completed</p> <p><input type="checkbox"/> Other/Specify:</p> <p><input type="checkbox"/> No</p>
<p>4.f Documentation of assessment of medication side-effects and patient teaching [SA Standard 1.2.d]</p>	<p><b>1</b> Does chart contain documentation of routine and appropriate side-effect assessment?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> Indicate methods used (check all that apply):</p> <p><input type="checkbox"/> Laboratory monitoring</p> <p><input type="checkbox"/> Patient interview</p> <p><input type="checkbox"/> Patient physical assessment</p> <p><input type="checkbox"/> Other/Specify:</p> <p><input type="checkbox"/> No</p> <p><b>2</b> Does chart contain documentation of routine and appropriate teaching patient about medications?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> Indicate methods used (check all that apply):</p> <p><input type="checkbox"/> 1:1 teaching by health care team.</p> <p><input type="checkbox"/> Materials given to patient.</p> <p><input type="checkbox"/> Referring patient to educator or group sessions.</p> <p><input type="checkbox"/> Other/Specify:</p> <p><input checked="" type="checkbox"/> Indicate content documented (check all that apply):</p> <p><input type="checkbox"/> Expected benefit of medications.</p> <p><input type="checkbox"/> Common and potentially serious side-effects of medications.</p> <p><input type="checkbox"/> Importance of medication adherence.</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Other/Specify:</p>

<p>4.g Documentation of monitoring of treatment plan goal attainment through the use of appropriate treatment assessment.</p> <p>Inclusion of patient in monitoring. [SA Standard 1.2.f]</p>	<p>❶ Methods of treatment assessment documented (check all that apply):</p> <p><input type="checkbox"/> Toxicology screening: <input type="checkbox"/> Blood <input type="checkbox"/> Urine  <input checked="" type="checkbox"/> Did client have any positive toxicology screens while in treatment?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Screening results not documented</p> <p><input type="checkbox"/> Other laboratory tests: <input type="checkbox"/> CD4 <input type="checkbox"/> Viral Load <input type="checkbox"/> Other:</p> <p><input type="checkbox"/> Patient self-report:  <input type="checkbox"/> Standardized instrument used <input type="checkbox"/> "Informal" patient interview</p> <p><input type="checkbox"/> Documentation of status of patient's substance abuse treatment service.</p> <p><input type="checkbox"/> Documentation of multi-disciplinary meetings/collaboration with other service providers that includes substance abuse treatment.</p> <p><input type="checkbox"/> Documentation of social indicators used for assessing treatment :  <input type="checkbox"/> Employment/employment training  <input type="checkbox"/> Housing stability  <input type="checkbox"/> Adherence with medical appointments  <input type="checkbox"/> Adherence with case management appointments  <input type="checkbox"/> Adherence with parole requirements  <input type="checkbox"/> Adherence with child welfare requirements  <input type="checkbox"/> Other/Specify</p> <p>❷ Does chart contain documentation of patient inclusion in monitoring/assessment?  <input type="checkbox"/> Yes  <input type="checkbox"/> No</p>				
<p>4.h Documentation of treatment plan reassessment at least every three months. [SA Standard 1.2.g]</p>	<p>❶ Does chart contain a treatment plan for the client?  <input type="checkbox"/> No <input checked="" type="checkbox"/> <b>GO TO 4.i</b>  <input type="checkbox"/> Yes</p> <table border="1" data-bbox="735 1150 1503 1312"> <tr> <td>Number of months of service provision during review period: (March 1, 2001 to February 28, 2002)</td> <td></td> </tr> <tr> <td>Number of reassessments documented:</td> <td></td> </tr> </table> <p>❷ Does chart contain documentation that treatment plan was reassessed at least every three months during the period of service provision?</p> <p><input type="checkbox"/> No <input checked="" type="checkbox"/> <b>GO TO 4.i</b>  <input type="checkbox"/> Not applicable: Client received services less than three months, so a reassessment was not indicated.  <input checked="" type="checkbox"/> Check here, if treatment plan was reassessed during the first three months of service provision. <input checked="" type="checkbox"/> <b>GO TO 4.i</b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> <b>CONTINUE</b></p> <p style="text-align: right;"><i>This question (4.h) continues on next page. ➞</i></p>	Number of months of service provision during review period: (March 1, 2001 to February 28, 2002)		Number of reassessments documented:	
Number of months of service provision during review period: (March 1, 2001 to February 28, 2002)					
Number of reassessments documented:					

	<p><b>3</b> Based on the documentation in the chart, should the reassessment of the care plan have led to development of new goals/objectives/outcomes?</p> <p><input type="checkbox"/> <b>Yes</b>, treatment plan content needed to be updated based on the documentation in the client chart.</p> <p><input checked="" type="checkbox"/> Was treatment plan?</p> <p><input type="checkbox"/> Appropriately updated; new goals/objectives outcomes established as indicated.</p> <p><input type="checkbox"/> Not updated as indicated.</p> <p><input type="checkbox"/> <b>No</b>, initial/previous treatment plan content was still appropriate.</p>
4.i Discharge planning/continuity of care	<p><b>1</b> Did client complete/was terminated from a substance abuse treatment service during the review period?</p> <p><input type="checkbox"/> No. Client continued to receive services. <input checked="" type="checkbox"/> <b>END OF CHART REVIEW</b></p> <p><input type="checkbox"/> Information not provided. <input checked="" type="checkbox"/> <b>END OF CHART REVIEW</b></p> <p><input type="checkbox"/> Yes. Client completed/was terminated.</p> <p><input checked="" type="checkbox"/> Check below documented reason for termination.</p> <p><input type="checkbox"/> Client completed treatment services.</p> <p><input type="checkbox"/> Client was terminated from treatment services.</p> <p><input checked="" type="checkbox"/> State reason for termination:</p> <p><input type="checkbox"/> Reason for termination not documented.</p> <p><b>2</b> Does chart contain documentation of appropriate discharge planning for client?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><b>3</b> Does chart contain documentation of inclusion of client in discharge planning?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><b>4</b> Does chart contain documentation of adequate follow-up/aftercare/contingencies?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><b>5</b> Does chart contain documentation of appropriate referrals to primary care?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Not applicable: Client already successfully linked to primary care</p> <p><b>6</b> Does chart contain documentation of appropriate referrals to case management?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Not applicable: Client already successfully linked to case management</p> <p><b>7</b> Does chart contain documentation of appropriate referrals to ancillary care?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Not applicable. Referrals not indicated.</p>

**BCHD Quality Improvement Project  
Substance Abuse Treatment Services  
Agency Survey**

---

- ▶ Agency Name:
- ▶ Address:
- ▶ Person completing form:
- ▶ Telephone:
- ▶ Fax:
- ▶ E-mail:

---

Please check all of the services that your agency **directly provided**, on-site during Title I fiscal year 2001 (March 1, 2001-February 28, 2002). **Note:** Do not limit your responses only to services funded by Ryan White Care Act.

- |   |  |
|---|--|
| <input type="checkbox"/> Ambulatory Health Care       | <input type="checkbox"/> Food/Nutrition        |
| <input type="checkbox"/> Mental Health Services       | <input type="checkbox"/> Housing Assistance    |
| <input type="checkbox"/> Outreach                     | <input type="checkbox"/> Legal Services        |
| <input type="checkbox"/> Substance Abuse Treatment    | <input type="checkbox"/> Enriched Life Skills  |
| <input type="checkbox"/> Inpatient Detoxification     | <input type="checkbox"/> Co-morbidity Services |
| <input type="checkbox"/> Outpatient Detoxification    | <input type="checkbox"/> Viral Load Testing    |
| <input type="checkbox"/> Long-term Structured Program | <input type="checkbox"/> Other/Specify:        |
| <input type="checkbox"/> LAMM                         |  |
| <input type="checkbox"/> Methadone                    |  |
| <input type="checkbox"/> 12-step Programs             |  |
| <input type="checkbox"/> Individual counseling        |  |
| <input type="checkbox"/> Other_____                   |  |
| <input type="checkbox"/> Transportation               |  |
| <input type="checkbox"/> Buddy/Companion              |  |
| <input type="checkbox"/> Case Management              |  |
| <input type="checkbox"/> Client Advocacy              |  |
| <input type="checkbox"/> Counseling                   |  |
| <input type="checkbox"/> Dental Care                  |  |
| <input type="checkbox"/> Direct Emergency Assistance  |  |

Please check all of the services that your agency does not directly provide on-site, but have **established (written) referral agreements** with other agencies to provide these services to your clients during Title I fiscal year 2001 (March 1, 2001-February 28 , 2002). **Note:** Do not limit your responses only to services funded by Ryan White Care Act.

- |   |  |
|---|--|
| <input type="checkbox"/> Ambulatory Health Care       | <input type="checkbox"/> Food/Nutrition        |
| <input type="checkbox"/> Mental Health Services       | <input type="checkbox"/> Housing Assistance    |
| <input type="checkbox"/> Outreach                     | <input type="checkbox"/> Legal Services        |
| <input type="checkbox"/> Substance Abuse Treatment    | <input type="checkbox"/> Enriched Life Skills  |
| <input type="checkbox"/> Inpatient Detoxification     | <input type="checkbox"/> Co-morbidity Services |
| <input type="checkbox"/> Outpatient Detoxification    | <input type="checkbox"/> Viral Load Testing    |
| <input type="checkbox"/> Long-term Structured Program | <input type="checkbox"/> Other/Specify:        |
| <input type="checkbox"/> LAMM                         |  |
| <input type="checkbox"/> Methadone                    |  |
| <input type="checkbox"/> 12-step Programs             |  |
| <input type="checkbox"/> Individual counseling        |  |
| <input type="checkbox"/> Other_____                   |  |
| <input type="checkbox"/> Transportation               |  |
| <input type="checkbox"/> Buddy/Companion              |  |
| <input type="checkbox"/> Case Management              |  |
| <input type="checkbox"/> Client Advocacy              |  |
| <input type="checkbox"/> Counseling                   |  |
| <input type="checkbox"/> Dental Care                  |  |
| <input type="checkbox"/> Direct Emergency Assistance  |  |

## Standards of Care

---

### A. Licensing, Knowledge, Skills and Experience

- Do all staff involved in the delivery of substance abuse treatment services have the appropriate and current professional licensure from the state of Maryland?  
☐ Yes   ☐ No
- Do all non-licensed staff and trainees delivering substance abuse treatment services receive professional supervision by licensed or certified providers?  
☐ Yes   ☐ No
- Do all substance abuse treatment staff have either specific experience in caring for HIV-infected patients or receive appropriate training?  
☐ Yes   ☐ No

4. Are substance abuse treatment providers encouraged to develop the expertise needed to provide the specialized care that HIV-infected patients need?

☐ Yes ☐ No

▶ If Yes, briefly describe how this is achieved?

5. If unlicensed providers will be providing services, has a formal letter of collaboration been established that outlines the nature and frequency of supervision received by specific certified/licensed providers?

☐ Yes ☐ No

## **B. Patient Rights and Confidentiality**

6. Does the agency have written policies and procedures that assure patient confidentiality (in accordance with Maryland Annotated Code) with regard to transmission, maintenance and security of medical information?

☐ Yes ☐ No

7. Does the agency have written policies and procedures regarding the provision of culturally appropriate care to their patients?

☐ Yes ☐ No

8. Do all substance abuse treatment staff have experience caring for or training working with the following groups:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Men having sex with men
<input type="checkbox"/> Yes	<input type="checkbox"/> No	African-Americans
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Persons with substance abuse history

9. Does the agency have written policies and procedures regarding the provision of services regardless of sexual orientation of the patient?

☐ Yes ☐ No

10. Does the agency have written policies and procedures regarding:

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Confidentiality                                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Equal access to care                                  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Provision of service regardless of sexual orientation |

### **C. Access, Care and Provider Continuity**

11. New patient evaluations are generally conducted within:

- ☐ The same day as the referral
- ☐ 5 days or less
- ☐ 6-10 days
- ☐ Greater than 10 days

12. Does the agency have mechanisms in place for urgent care evaluation and/or triage?

- ☐ Yes   ☐ No

▶ If Yes, describe these mechanisms.

13. Does the agency have mechanisms in place to facilitate access to the following services

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Inpatient detoxification                             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Outpatient detoxification                            |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Twelve-step programs                                 |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Long-term structured programs, e.g., half-way houses |

▶ If Yes, briefly describe these mechanisms.

14. Does the agency have mechanisms in place to ensure continuity of substance abuse treatment to their patients in the following care settings:

- |                              |                             |                                    |
|------------------------------|-----------------------------|------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Day programs                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Day hospitals                      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mental health programs             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Inpatient psychiatric units        |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Inpatient medical units            |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chronic care units (nursing homes) |

▶ If Yes, briefly describe these mechanisms.

15. Has the agency developed and maintained linkages with mental health treatment service providers to maintain care continuity for patients with dual diagnoses?

- ☐ Yes   ☐ No

▶ If Yes, briefly describe these mechanisms.

16. Has the agency developed and maintained written memorandum of understanding/agreement to ensure care continuity with:

- |                              |                             |                           |
|------------------------------|-----------------------------|---------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Case management providers |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Primary care providers    |

#### **D. Quality Improvement**

17. Does the agency have an on-going quality improvement/quality assurance program for substance abuse treatment services that identifies areas for improvement and subsequent actions taken?

- ☐ Yes   ☐ No

18. Are utilization review decisions based on best practice and consistent with emerging national standards?

☐ Yes ☐ No

19. Has the agency considered providing access to staff on a 24-hour basis?

☐ Yes ☐ No

▶ If Yes, Is 24-hour access to staff now available?

☐ Yes ☐ No

▶ If No, describe the reasons why this has not been implemented.

# OPERATIONAL & PERFORMANCE STANDARDS FOR SUBSTANCE ABUSE TREATMENT PROVIDERS

*revised: August 2001, ratified: August 2001*

## STANDARD OF CARE 1.0

Substance abuse treatment for persons with HIV disease should reflect competence and experience in evaluation, formulation, and diagnosis as well as in evidence-based therapeutics, using contemporary practice guidelines where available.

The following components of evaluation and treatment should be standard practice with all patients/clients and be reflected in medical record documentation:

**1.1 AN INITIAL EVALUATION MUST BE CONDUCTED PRIOR TO THE INITIATION OF ANY TREATMENT. THIS EVALUATION MUST BE CONDUCTED BY CLINICAL STAFF WHO ARE KNOWLEDGEABLE ABOUT THE FULL SPECTRUM OF ALCOHOL AND DRUG ADDICTION. CLINICAL STAFF SHOULD BE WORKING IN A SUBSTANCE ABUSE PROGRAM CERTIFIED/LICENSE BY EITHER THE STATE OF MARYLAND OFFICE OF HEALTH CARE QUALITY ACCREDITATION ON REHABILITATION FACILITIES; OR HOLD A CURRENT CERTIFICATION/LICENSE WHICH IS RECOGNIZED BY THE MARYLAND ALCOHOL AND DRUG ABUSE ADMINISTRATION FOR PRACTICE IN THE STATE OF MARYLAND. THE EVALUATION MUST CONSIST OF THE FOLLOWING:**

- a. History: chief complaint, current substance use history, past substance use history, family history, social and personal history, medical history, review of systems, current and recent medications, premorbid personality, and past psychiatric history.
- b. Complete mental status evaluation appearance and behavior, talk, mood, vital sense, self attitude, suicidal risk, homicidal risk, abnormal beliefs (delusions, overvalued ideas), perceptual disturbances (hallucinations, illusions), obsessions/compulsions, phobias and panic attacks.
- c. Cognitive assessment: level of consciousness, orientation, memory, language, praxis, executive (may substitute the Mini-Mental Status and Verbal Trails Test).
- d. Complete the Addiction Severity Index (ASI) or the Problem Oriented Screening Instrument for Teenagers (POSIT).
- e. Laboratory studies, as indicated (e.g. blood alcohol level, toxicology screen).
- f. Multi-axial differential diagnosis leading to final diagnostic formulation, with special emphasis on the identification of co-morbid mental disorders.
- g. A care plan with specific measurable treatment goals through the use of appropriate outcome assessment. This care plan must address the full range of substances the patient/client is abusing, including alcohol, nicotine, opiates (e.g., heroin), stimulants (e.g., cocaine), inhalants and others. The care plan must include input from the patient/client.
- h. Practice guidelines for substance use disorders, such as those published by the American Society of Addiction Medicine.

**1.2 FOLLOW-UP VISITS TO PROVIDE OR MONITOR TREATMENTS AND TO ASSESS PROGRESS TOWARD MEETING GOALS**

- a. Visit frequency will be based on level of care and severity of need.
- b. The provision of supportive and educational counseling at all visits. This should include counseling regarding the prevention of HIV-transmitting behaviors and substance abuse as clinically indicated.
- c. The prescription and monitoring of appropriate psychotropic or other medications, such as LAAM and Methadone, as indicated by the clinical situation, based on practice guideline recommendations, and linked to specific treatment goals. Medications must be provided under the supervision of a physician/psychiatrist.
- d. Medication side effect assessment and teaching for patients on medications.
- e. The provision of group psychotherapy or counseling as indicated by the clinical situation based on practice guideline recommendations and linked to treatment goals.
- f. Monitoring of progress toward treatment plan goals through the use of appropriate outcome assessment. This must also include input from the patient/client.
- g. Reassessment of each patient/client's treatment plan at least every three months.

## **STANDARD OF CARE 2.0**

HIV substance abuse treatment providers must show compliance with the following standards regarding: (a) licensure and qualifications of care providers; (b) confidentiality and regard for patient rights; (c) access, cultural appropriateness, and continuity of care; and (d) quality of care improvement efforts.

### **2.1 LICENSING, KNOWLEDGE, SKILLS, AND EXPERIENCE**

- a. All agencies and staff delivering substance abuse treatment services will possess current certification and/or licensure.
- b. Non-licensed staff and trainees delivering substance abuse treatment services will receive professional supervision of the care they are providing to individual patients/clients by licensed or certified providers.
- c. All staff delivering substance abuse treatment services will either have specific experience in caring for HIV-infected patients or receive appropriate training.

### **2.2 PATIENT RIGHTS AND CONFIDENTIALITY**

- a. The provider organization will provide assurances and a method of protection of patient rights in the process of care provision.
- b. The provider organization will provide assurances and a method of protection of patient confidentiality (in accordance with Maryland Annotated Code), with regard to medical information transmission, maintenance and security.
- c. The provider organization will provide assurances regarding the provision of culturally appropriate care to their patients/clients. Specifically, the providers must have training or experience with caring for those groups most affected by the epidemic, such as gay men, African-Americans, and substance abusing persons.
- d. The provider organization will provide assurances that substance abuse treatment services will be provided regardless of the sexual orientation of the client/patient, respect confidentiality and equal access will be assured.
- e. If unlicensed providers will be providing services, a formal letter of collaboration must detail the nature and frequency of supervision received by specific certified/licensed providers.

### **2.3 ACCESS, CARE AND PROVIDER CONTINUITY**

- a. The provider organization will provide clinical services in a timely fashion to all patients/clients. New patient/client evaluations will generally be conducted within 5 working days of notification of the provider.
- b. The provider organization will provide mechanisms for urgent care evaluation or triage.
- c. If clinically indicated, the provider organization will facilitate patients/clients access to services such as: the full range of substance abuse treatment settings including, but not limited to; detoxification (inpatient and outpatient), twelve-step programs, and long-term structured treatment programs (e.g. half-way houses).
- d. The provider organization will have a system that ensures continuity of substance abuse treatment to their patients/clients in all settings in which they may receive care, including, but not limited to day programs, day hospitals, mental health programs, inpatient psychiatric units, inpatient medical units, and chronic care units (nursing homes).
- e. The provider organization will develop and maintain linkages with mental health treatment service providers, such as to maintain care continuity for patients with dual diagnoses of substance use disorders and other mental disorders.
- f. The provider organization must develop and maintain formal memorandum of understanding/agreement with case management and/or primary medical care provider to ensure care continuity.

### **2.4 QUALITY IMPROVEMENT**

- a. The provider organization will provide for methods to monitor for areas in need of improvement.
- b. The provider organization will provide for methods for the development of corrective action and the assessment of the effect of such actions, regarding areas in need of improvement. Providers must consider providing access to their staff on a 24-hour basis.
- c. Utilization review decisions will be clinically based on best practice and consistent with emerging national standards.